



Physician's Order Form of Medical Necessity

Patient Information

Name _____ Date Of Birth _____

Phone Number _____

Referring Provider Information:

Referring Practice: _____

Referring Provider: _____ NPI # _____

Physician Signature: _____ Date: _____

Evaluate & Treat

☐ Grants permission for Advanced Prosthetics to evaluate and treat patient by our clinician.

Prescription Information: ☐ Right ☐ Left ☐ Bilateral

Rx

PLEASE ATTACH DEMOGRAPHIC AND INSURANCE INFORMATION

GREENVILLE

6 N Old Grove Road
Greenville, SC 29605
Fax: 864.552.9773
Phone: 864.552.9772

COLUMBIA

720 Gracern Road Suite 115
Columbia, SC 29210
Fax: 803.509.6254
Phone: 803.509.6256

SPARTANBURG

790 North Church Street
Spartanburg, SC 29303
Fax: 864.504.3449
Phone: 864.504.3490

GREER

1 Brushy Meadows Drive
Greer, SC 29650
Fax: 864.989.1947
Phone: 864.989.1946

EASLEY

1661 East Main Street
Easley, SC 29640
Fax: 864.855.9331
Phone: 864.859.4709

ANDERSON

703 North Fant Street Suite A
Anderson, SC 29621
Fax: 864.622.0585
Phone: 864.622.0900

GASTONIA

2550 Court Drive, Suite 101
Gastonia, NC 28054
Fax: 704.671.2170
Phone: 704.671.2061

