Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

HEALTH AND RECOVERY SERVICES ADMINISTRATION (HRSA) PRESCRIPTION FORM

This prescription is valid for one (1) year from date signed.

SECTION I

PATIENT'S NAME	DATE OF BIRTH

DIAGNOSIS

LENGTH OF NEED

☐ Indicate rental if applicable ☐ Less than 6 months ☐ Greater than 6 months ☐ Number of months _____

SECTION II

ITEM	QUANTITY	SUPPLIES – FREQUENCY OF USE

SECTION III

PHYSICIAN'S PRINTED NAME	TELEPHONE NUMBER	FAX NUMBER	REFERRING PHYSICIAN'S NUMBER

PHYSICIAN'S ADDRESS	CITY	STATE	ZIP CODE

I certify that I am the physician identified in Section III of this form and that the medical necessity information in Section I and II is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in those sections may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTED).

PHYSICIAN'S SIGNATURE	DATE SIGNED