



When completed, please fax to 866.498.9635

Blood Pressure Monitor Prescription

Provider Name:

Patient Name:

Phone:

Date of Birth:

Fax:

Date of face to face visit:

NPI:

Length of Need (in months):

Diagnosis and ICD-10 code

I10 Essential primary hypertension

Other

Item:

Blood Pressure Monitor

Prescriber Signature _____ Date _____