Physician's Permission and Signature Form

(Practice)

Section One: Practice Information

Practice/Facility Name: _____

Physical Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Section Two: Authorization

(First individual listed will be the primary authorized staff member to place orders on behalf of the physician listed below)

(PRIMARY)

Name 1: _____ Title: _____ Email: _____

Name 2: _____ Title: _____ Email: _____

Name 3: _____ Title: _____ Email: _____

Section Three: Physician's Signature

Print Physician's Name: _____ Email: _____

Physician's NPI Number: _____ Medicaid Number: _____

Please sign inside the box to the right. By signing this form, you are giving the staff named above the right to order on the GoScripts system on your behalf and with your instruction.

Trading Partner Agreement

Legal Notice to the Physician: The supplier below provides this secure electronic service free to you through a license with GoScripts. Its purpose is to allow rapid and efficient transmissions of orders, CMNs, and other medical documents from the physician to the suppliers. This is not a transactional billing service for the physician but simply a way to communicate electronically between referral sources and participating HME vendors.

Your one-time signature will grant the listed authorized users access to orders and certificates of medical necessities. This signature resides on an encrypted-key server inside a secure facility.

Initiating Company _____ City _____ State _____

Representative _____ Phone _____ Email _____

Please fax or email this form to GoScripts once completed:

Fax: (866) 851-8569 | Email: goscriptsenrollmentform@brightree.com