Information Regarding Innovus OTC Consumer Care Product Costs
(Reimbursement – Healthcare FSA, HRA or HSA)

Patient Name: _____

Patient Date of Birth: _____

Name of Prescribing Healthcare Provider: _____

Address of Prescribing Healthcare Provider: _____

_____

Prescribing Healthcare Provider Telephone Number and Email:_____

_____

Patient diagnosis/diagnoses:_____

_____

Innovus OTC Consumer Care product recommended for treatment of diagnosis/diagnoses:

_____

I have prescribed or recommend the above listed natural/dietary supplements as treatment for the above specific diagnosed medical condition(s).

_____

Signature of Prescribing Healthcare Provider Date