CERTIFICATE OF MEDICAL NECESSITY

PRINT CLEAR FORM

HEALTH INSURANCE CLAM #:	PROVIDER:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY STATE ZIP	CITY STATE ZIP
PHONE:	PHONE:

PRESCRIPTION DATE: __ / __ / ____ LIFETIME USE: _____

ICD-10: _____

DEVICE: _____

JUSTIFICATION:

PROCEDURE CODE	DESCRIPTION

Signature of Physician certifies that the above represents his judgement of the patient's need for the item(s).

Physician's Name: _____

Physician's Phone: _____

CITY STATE ZIP

Physician's Address: _____

Physician's Sigature: _____ Date: __ / __ / ____ NPI: _____