

# Certificate of Medical Necessity

*A requirement of your patient's health insurance or the Board of Equalization*

Insurance Policy Group Number \_\_\_\_\_ Member ID \_\_\_\_\_

\_\_\_\_\_  
Patient Name (Last, First, Middle)

Gender:  M  F

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date of Birth (mm/dd/yyyy)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_) \_\_\_\_\_  
Phone

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Prescription Date (mm/dd/yyyy)

\_\_\_\_\_  
Diagnosis Code Diagnosis

Reason why products are necessary:

\_\_\_\_\_  
\_\_\_\_\_

Billing Code      Required Medical Items  
HCPCS-E1399      Durable Medical Equipment, Miscellaneous

## Physician Information

\_\_\_\_\_  
Physician's Name **IMPORTANT: PLEASE PRINT CLEARLY**

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_) \_\_\_\_\_  
Phone

\_\_\_\_\_  
Physician's Signature Date \_\_\_\_/\_\_\_\_/\_\_\_\_