CERTIFICATE OF MEDICAL NECESSITY

Support Surfaces - Group 1

Cert Type:

Eff. Date:

Patient, Address, Phone

Account No.:
Patient DOB: **Sex:** **HT:** **WT:**
Physician

Provider Name, Address, Phone and Fax Number, NSC Num

Fax:
NSC#:
Physician's License #: **UPIN#:**

Diagnosis Codes & Descriptions

Primary insurance:
Secondary insurance:

Items: HCPCs: Supplier Charge: Allowable:

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.
Indicate which of the following conditions describe the patient. Circle the number for all that apply:

1) Completely immobile (i.e. patient cannot make changes in body position without assistance)

2) Limited mobility (i.e. patient cannot independently make changes in body position significant enough to alleviate pressure)

3) Any pressure ulcer on the trunk or pelvis

4) Impaired nutritional status

5) Fecal or urinary incontinence

6) Altered sensory perception

7) Compromised circulatory status

If none of the above applies, please attach a separate sheet documenting the medical necessity for the items ordered.

Duration of Need: ____________ 1-99 (99=Lifetime)

Physician Attestation

I certify that I am the physician identified above. I have received the information of the Certificate of Medical Necessity. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information on this form is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact in that information may subject me to criminal or civil liability.

PHYSICIAN'S SIGNATURE ________________________________ DATE ______ /______ /______ (*DO NOT STAMP*)