MEDICAL NECESSITY FORM

Patient Name: _____

Date of Birth: _____

Insurance ID / Policy Number: _____

Ordering Physician Information:

Physician Name: _____

NPI Number: _____

Phone Number: _____

Address: _____

Supplier / Provider Information:

Supplier Name: _____

Phone Number: _____

Address: _____

Equipment / Service Requested:

Equipment / Service Description: _____

HCPCS / CPT Code(s): _____

Quantity: _____ Duration of Need: _____

Clinical Diagnosis and Justification:

Provide detailed clinical rationale for the medical necessity of the requested equipment or service. Include diagnosis, symptoms, functional limitations, and any relevant clinical findings or test results. Explain why the requested item or service is essential for the patient's treatment plan and that less costly alternatives are not appropriate.

Physician Certification and Signature:

I certify that the information provided is true and correct to the best of my knowledge, and that the equipment or service is medically n

Physician Signature: _____

Date Signed: _____

Patient Acknowledgment:

I acknowledge that I have received and understand the information provided in this Medical Necessity Form. I authorize the release of any medical or other information necessary to process claims related to this request.

Patient Signature: _____

Date Signed: _____

Additional Comments / Instructions:

_____

PHYSICIAN SIGNATURE

Signature: _____

Date: _____

PATIENT SIGNATURE

Signature: _____

Date: _____