

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 necessary.

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

PATIENT SIGNATURE

Signature: _____

Signature: _____

Date: _____

Date: _____

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