



Please print this form, have your doctor fill it out, and send it directly to your insurance provider along with a copy of your invoice showing product purchase.

Certificate of Medical Necessity

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

Patient Information

Name _____ Date of Birth _____ M F

Street Address _____ City _____ State _____ Zip _____ Phone _____

Prescription Date _____ Renewal _____ HIC# _____ Initial _____

Insurance Company(s) _____ Policy/Group Number(s) _____

#1 _____ #1 _____

#2 _____ #2 _____

Diagnosis Code Diagnosis (if necessary, list additional items on back)

Reason why products are necessary:

Billing Code Required Medical Items(if necessary, list additional items on back)

Note: Use billing code HCPCS-E1399 Durable Medical Equipment (DME), Miscellaneous, or HCFK0183 for Sinus Irrigators.

Physician Information

Physician's Name _____ Phone Number _____

Patient's Prognosis _____ Date last seen PRIOR to this prescription _____

Street Address _____ City _____ State _____ Zip _____

Medi-Cal Provider Number _____ Unique Physician ID Number (UPIN) _____

Physician's Signature _____ Date _____