Certificate of Medical Necessity

Participant's Name: ____

Participant's Social Security Number: ______________________________

Patient's Name: ____

Medical equipment needed (including accessories):

____

____

Date of medical need: ____

Equipment will be needed for: ____ Weeks ____ Months ____ Indefinitely ____ Permanently

Special feature(s) such as electronically operated bed or wheelchair required because disability precludes the use of standard equipment (please explain):

____

____

Diagnosis: ____

Prognosis: ____

Patient's current status (check all that apply):

____ Confined to room
____ Confined to chair
____ Confined to bed
____ Ambulation impaired
____ Unable to ambulate
____ Hypoxemic with exercise
____ Other (please describe) ______________________________________
____ Body positioning required that would not be feasible in ordinary bed
____ Periodic movement necessary to retard deterioration
____ Substantial therapy required under physician's supervision

Place where equipment will be used:

____ Patient's home
____ Patient's apartment
____ Relative's home
____ Home for the aged
____ Nursing home (not a skilled nursing facility)
____ Other (please describe) ______________________________________

(over, please)

Medical equipment supplier's name and address:

Name of supplier: ____
Address: ____
City: ____________________ State: ______________ Zip: ______________

Participant's address (where equipment will be used):

Address: ____
City: ____________________ State: ______________ Zip: ______________

I hereby certify that the above equipment is medically necessary for the treatment of this patient's illness or injury.

______________________________________ ____________________
Physician's Signature Date

____
Address

____
City State Zip