

PHYSICIANS STATEMENT OF MEDICAL NECESSITY

This statement of Medical Necessity requests information required by our patient's insurance company or Medicare to process claims for the medical device listed below.

Please sign and date this form upon completion.

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Social Security # _____

The patient requires a: _____

Diagnosis Code # _____

Estimated length of need _____ 6 months

_____ Long term

_____ Other

Physician's signature : _____ Date: _____