Your Hospital's Logo Here

CERTIFICATE OF MEDICAL NECESSITY

Medicare regulations require the following information be provided on claims for durable medical equipment. This form should be completed by the beneficiary's physician and returned to use with a completed Medicare claim form:

PATIENT'S NAME:	HEALTH INSURANCE CLAIM NO.:
DIAGNOSIS:	

DATE THIS EQUIP PRESCRIBED:	EQUIP WILL BE NEED FOR: _____ Months	PROGNOSIS:

Please check the equipment your are prescribing & answer "YES" or "NO" to the corresponding questions. Describe equipment with special attachments or features not listed in the space provided below.

EQUIPMENT	CORRESPONDING QUESTION(S)	
☐ Cane	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Commode	☐ Patient is bed confined	☐ Patient is room confined
☐ Crutches - Child	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Crutches - Adult	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Crutches - Adult	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Hand Splint		☐ Equipment used for therapy
☐ Quad Cane - Small Base	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Quad Cane - Wide Base	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Walker - Standard	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy
☐ Walker - Rolling	☐ Patient's condition impairs ambulation	☐ Equipment used for therapy

DESCRIBE ANY ADDITIONAL EQUIPMENT NEEDED (NOT LISTED ABOVE) & THE DIAGNOSIS / CONDITION WHICH WARRANTS EQUIPMENT

IF EQUIPMENT IS NOT USED IN THE PATIENT'S HOME, INDICATE NAME/ADDRESS OF FACILITY WHERE THE PATIENT RESIDES.

IMPORTANT: THIS FORM MUST BE SIGNED AND DATED BY PRESCRIBING PHYSICIAN BEFORE EQUIPMENT MAY BE CONSIDERED FOR PAYMENT:

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE: _____

ADDRESS: _____

PHYSICIAN'S SIGNATURE:	DATE:

WHITE = Medical Record **YELLOW** = DME Dept