



Medical Reimbursement Form
Print out this form, have your physician fill it out, and send the signed certificate, along with your product invoice, to your insurance provider for a possible reimbursement.

Certificate of Medical Necessity

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

Patient Name: _____ Date of Birth: _____ Sex: M F

Address: _____ Telephone: _____

Prescription Date: _____ Renewal HIC#: _____ Initial: _____

Insurance Company(s)	Policy/Group Number(s)
1. _____	1. _____
2. _____	2. _____

<u>Diagnosis Code</u>	<u>Diagnosis</u> (If necessary, list additional items on the back.)
_____	_____
_____	_____

Reason why products are necessary:

<u>Billing Code</u>	<u>Required Medical Items</u> (If necessary, list additional items on the back.)
_____	_____
_____	_____

Note: Use billing code HCPCS-E1399 Durable Medical Equipment (DME), Miscellaneous

Physician's Name: _____ Telephone: _____
Street Address: _____

Medi-Cal Provider Number: _____ Unique Physician ID Number: _____

Patient Prognosis: _____ Date last seen PRIOR to this prescription: _____

Physician's Signature: _____ Date: _____