



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. \_\_\_\_\_

Diagnosis Code	Diagnosis (If necessary, list additional items on the back.)
_____	_____
_____	_____

Reason why products are necessary:  
\_\_\_\_\_  
\_\_\_\_\_

Billing Code Required Medical Items (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 : \_\_\_\_\_