HOME MEDICAL INC

6550 N Hamlin Ave Lincolnwood, IL 60712 Phone: 847-480-9390 Fax: 847-480-9394

Physician Written order & Certificate of Medical Necessity

Patient Information

Last Name: First Name:

Date of Birth: Gender: Height: Weight:

Address:

Phone#: Insurance #:

βThe following equipment is needed by the beneficiary as a medical necessity

- ☐ Auto B/P Monitor (A4670)
- ☐ Breast Pump, Electric (E0603)
- ☐ Lumbar Orth, Flex OTS (L0625)
- ☐ Arm Sling (A4565)

ICD-10 DX:

- ☐ I10– (Hypertension)
- ☐ Z39.1 (Encounter for care & examination of lactating mother)
- ☐ R29.898 (Sym for muscoskeletal sys.)
- ☐ M54.59 (Low back pain, site unspecified))

Other Diagnosis (ICD-10):

By signing below, I authorize the use of this document as a legal prescription, and certify that the above prescribed supply is medically necessary and reasonable, and this patient meets all requirements and medical necessity for above prescribed supply. Information provided is true and supported in the patient's Medical Record.

Physician Information

Physician Name: NPI Number:

Address:

Phone: Fax:

Physician Signature: Date: