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 : _____