847-824-0500 * PULMONARY PROVIDERS GROUP, INC. * 847-824-0529 fax

CERTIFICATE OF MEDICAL NECESSITY

Blood Pressure Monitor Order Form

Referral Source:______________________ Referral Source Phone:_________________________

PATIENT INFORMATION

Last Name:___________________________________ First Name:____________________________________

Address: ____

City:____ State: Illinois Zip code:___________________

Phone Number: (_______)______________________

Sex: Female__________ Male___________ Birth Date:_____/_____/__________

Height:_________ Weight:_________

DIAGNOSIS INFORMATION

Primary :____

Secondary:____

INSURANCE INFORMATION

Medicare Number:_____NOT COVERED_____

Medicaid Recipient Number:____

Managed Care Medicaid Name:______________________________________ Policy:___________________________

Private Ins. Name:____ Policy:___________________________

PRODUCT(S) REQUESTED

Blood Pressuer Monitor = [BPM] Length of Need:_______(1-99 Months) 99=Lifetime

[ ] Digital BPM auto inflate [ ] Digital BPM manual inflate [ ] Manual BPM

[ ] Large Cuff [ ] Extra Large Cuff

The patient's medcial record must contain the following information

Please document the last 3 BP readings: 1.)________/________, 2.)________/________, 3.)________/________

PHYICIAN INFORMATION

Print Name:____

Address:____

City:________________________________ State:________________________________ Zip code:___________________

Phone Number:(_______)______________________________

NPI:____

I, the undersigned, certify that the above prescribed Durable Medical Equipment/Supplies are medically necessary as a part of my treatment for this patient. In my opinion, the equipment/item(s) prescribed are reasonable and necessary for the accepted standards of medical practice and treatment in patient's condition.

Physician Signature:____ Date:________/_______/____________