Certificate of Medical Necessity Form

For supplies/medical equipment without specific CMN

BlueCross BlueShield of Kansas*

www.bcbsks.com

Section 1

SECTION 1: CERTIFICATION DATE: INITIAL ________ /________ /________ REVISED________ /________ /________

Patient Name ____
Printed or Typed

Address ____
Street

________________________ ________ ________ ________
City State ZIP Code County

Telephone (______) ______ - __________ ID# ______________________

Supplier Name ____
Printed or Typed

Address ____
Street

________________________ ________ ________ ________
City State ZIP Code County

Telephone (______) ______ - __________ NPI#______________________

Physician Name ____
Printed or Typed

Address ____
Street

________________________ ________ ________ ________
City State ZIP Code County

Telephone (______) ______ - __________ NPI#______________________

PT DOB _____/_____/_____ SEX _________(M/F) HEIGHT_________ WEIGHT_________

Section 2

SECTION 2: MEDICAL NECESSITY INFORMATION (Physician if this section is blank please complete)

Estimated length of need (# of months): ______________________
1 through 99 (99 = lifetime)

Diagnosis codes (ICD-9): __________ - ______/

__________ - ______/ __________ - ______/

__________ - ______/ __________ - ______/

Give brief description of supply/medical equipment prescribed: (Complete and attach additional sheet if needed.)

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____

Briefly list specific patient physical imitations/conditions pertinent to request: (Complete and attach additional sheet if needed.)

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Section 3

SECTION 3: PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I certify that I am the physician identified in Section A of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Physician's Signature ______________________________ **Date** ______ /______ /______

*An Independent Licensee of the Blue Cross and Blue Shield Association.