

Certificate of Medical Necessity Form



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Lymphedema Compressor

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: 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): _____ - _____/
_____ - _____/ _____ - _____/
_____ - _____/ _____ - _____/

- YES NO Does the patient have a malignant tumor with obstruction of the lymphatic drainage of extremity?
- YES NO Has the patient had surgery or radiation that interrupted normal lymphatic drainage or is there a congenital abnormality of lymphatic drainage?
- YES NO Is the device prescribed for the treatment of chronic venous insufficiency with edema and/or venous ulcers
- YES NO Is there intractable lymphedema?

What has the physician prescribed as the pressures to be used: _____

Frequency: _____

Duration of use of this device: _____

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 _____ / _____ / _____

Section 1

Section 2

Section 3