Words+, Inc.

Letter/Certificate of Medical Necessity

Patient Name: ___________________________________
Patient Address: _________________________________
____
____

Clinical Information:

Primary Diagnosis:_______________________ **ICD-9:**____________
Secondary Diagnosis:_____________________ **ICD-9:**____________
Duration of Need: ____

Equipment Requested:

_____________________________ __________________________
_____________________________ __________________________
_____________________________ __________________________
_____________________________ __________________________

Statement from Physician of Medical need for Equipment Requested :
____
____
____
____

Physician Information:

Physician Name (printed) ______________________________________
UPIN #_________________________**NPI#**________________________
Address:____
____
Phone #:________________________**Fax#:**_______________________
Physician Signature:____
Date:___________________________

***This form is not required by Medicare.**
****Please be advised that this form may not be sufficient for approval from private insurance companies if submitted on its own merit.**
***** Completion of this form does not guarantee payment from any funding source.**

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