Your Sinus Rinse System May Be Insurance Reimbursable!

Please print this form, have your doctor fill it out, and send it directly to your insurance provider along with a copy of your invoice showing product purchase.

Certificate of Medical Necessity

A requirement of your patient's health insurance and/or the Board of Equalization

Patient Name: ____________________ DOB: __________ Prescription Date: ________
Initial: _____ Renewal: ____

Address & Phone: ____
____

Sex: M ____ F ___ HIC#: ______________________

Insurance Company (s): Policy/Group # (s):
#1 ______________________________ #1 ____________________________________
#2 ______________________________ #2 ____________________________________

Medical supplies and/or equipment will be needed for____ months from the above date.

Related Diagnosis with applicable diagnosis code (s):
____
____

Reason supplies and/or equipment is necessary:
____
____

Billing Code: Required Medical Items (if necessary, list additional items on back)
_______________ ____
_______________ ____
_______________ ____
_______________ ____
_______________ ____

Note: Use billing code HCPCS-E1399 Durable Medical Equipment (DME), Miscellaneous

Prognosis: __________________ Date last seen PRIOR to this prescription: __________
Physician's Name: __________________________ Phone Number: _________________
Complete Address:____
____

Medi-Cal Provider #:______________ Unique Physician ID Number (UPIN) __________
Physician's signature:________________________________ Date: _________________