CERTIFICATE OF MEDICAL NECESSITY

Dear Physician:

This certificate of medical necessity (prescription) requests information required by your patient's insurance company to process claims for the medical equipment and supplies listed below. Please fax or mail the completed Certificate of Medical Necessity to the party requesting this information.
Thank you.

Patient Name: ____
____/____/____
Address: ____
City, State Zip: ____
SS#/HIC#: ____

Date of Birth:

Height (inches): ___________
Weight (lbs.): _____________
Sex (M or F): _____________

PLEASE ANSWER ALL QUESTIONS

1. The patient requires: Medi-Jector Needle-Free Insulin Delivery System
   HCPCS Codes: A4210 (Injector) A4211 (Needle-Free Syringe Kits)

2. Primary Diagnosis:________________________ ICD-9 Code:______________

3. Date of initial need: ______/______/______

4. I last examined this patient for this condition on: ______/______/______

5. Total number of insulin injections per day (1-10): _______

6. Does patient have difficulty managing disease because of a physical or mental inability to self-inject with a needle? Yes _____ No _____

7. Does patient suffer from injection site damage (i.e.: lipohypertrophy, lipodistrophy, lipoatrophy, etc.)? Yes _____ No _____ If yes, please specify:
____

8. Please provide any additional information regarding the patient's need for this equipment in the space below:

____

____

____

9. Length of need (# of months): ________ 1-99 (99 = lifetime)

I certify the medical necessity of above item for this patient. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

Physician Signature: _______________________________ Date: ____/____/____ UPIN: ________

Physician Name: __________________________________ Phone: ____________________________

Address: ____ FAX: ____________________________

City, State, Zip: ____