Medical Necessity Update Form

PLEASE COMPLETE THE FORM IN ITS ENTIRETY AND RETURN WITH SIGNATURE OF PHYSICIAN OR REPRESENTATIVE FROM EQUIPMENT SUPPLIER

Account Information

Account #: ____________________

Account Name: ____

Last 4 Digits of Social Security #: ________________

Service Location Address: ____

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Home Phone: _________________________________

Mobile Phone: ________________________________

Name of Person Using Equipment: ____

Medical Equipment Information

Type of Equipment In Use: ____

Hours In Use: ____________________

Is this equipment necessary to sustain life? □ **Yes** □ **No**

Equipment Supplier: ____

Case Manager/Supplier Representative: __________________________________

Physician Name: ____

Physician or Supplier Signature (REQUIRED FOR VERIFICATION OF INFORMATION ABOVE):

Signature: **Date:**