Medical Necessity Update Form

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

Account Information

ACCOUNT # : _____

ACCOUNT-HOLDER NAME: _____

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: _____

SERVICE LOCATION ADDRESS: _____

_____

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 above information): _____

DATE: _____