200 PHARMACY
& MEDICAL SUPPLIES

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BREAST PROSTHESIS – CERTIFICATE OF MEDICAL NECESSITY

Medicare/Medicaid requires a certifying physician's signature for Mastectomy Products. Please fill out where indicated by asterisks, and return via fax/mail.

Patients Name: ____ D.O.B: ____________

Patients Address: ____

City: _____________________________ State: ___________________ Zip: _________

Phone #: ____________________________ ☐ FEMALE ☐ MALE HGT: ________ WGT:_______

Medicare #: _____________________ Medicaid #: _________________Other: ________________

Diagnosis: ____

ITEM/ SUPPLY DESCRIPTION:

☐ BREAST PROSTHESIS: QUANTITY (CIRCLE ONE) 1 2 Circle: RIGHT LEFT BOTH

☐ MASTECTOMY BRA: QUANTITY (CIRCLE ONE) 1 2 3 4 5 6

✓ YES THIS PATIENT REQUIRES THE ABOVE SUPPLIES

Physician Name: ___________________________________ NPI #: ______________________

Address: ____

City: _________________________ State: ____________________ Zip: ___________________

Phone #: ________________________________ Fax #: _____________________

Physician Signature: _______________________________________ Date: ___________________

YOUR PROMPT RESPONSE IS MOST APPRECIATED