Certificate of Medical Necessity

CompuMed Automated Medication Dispenser

HCPC Code S5185 **NAICS** 334510 **CAGE** 5NFF3

Patient

Name _____

Birthday ____/____/_____ ___M ___F

Address _____

City, ST Zip _____

Phone ( ) -

Medicaid # _____

Medicare # _____

Date ____/____/____ ____/____/____
evaluated prescribed

Service Provider (Physician, Agency, et al.)

Name _____

Address _____

City _____

Zip (9 digits) _____

Phone ( ) -

NPI # _____

Contact Person _____

Contact Phone ( ) -

Diagnosis Code Description

_____ _____

_____ _____

_____ _____

Medications used by patient (please include an attachment for additional medications)

Medication	Dosage	Frequency per day

Clinical Notes (Describe why medication management is necessary. Attach additional notes if needed.)

_____

_____

_____

_____

_____

_____

Physician certification

To the best of my knowledge, the above information is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. I authorize the release of any medical or other information necessary to process this claim.

_____ _____

Physician signature Date