Certificate of Medical Necessity

Form for lymphedema compressor

BlueCross BlueShield of Kansas

Section 1A – Patient Information

First Name _____ MI ___

Last Name _____ Suffix ___

Phone Number _____ ID Number _____

Date of Birth _____

Address _____

City _____

State ___ ZIP Code _____ +4 ____ County _____

Height _____ Weight _____

Section 1B – Supplier Information

Supplier Name _____

Phone Number _____ NPI Number _____

Address _____

City _____

State ___ ZIP Code _____ +4 ____ County _____

Section 1C – Physician Information

First Name _____ MI ___

Last Name _____ Suffix ___

Phone Number _____ ID Number _____

Address _____

City _____

State ___ ZIP Code _____ +4 ____ County _____

Section 2 – Medical Necessity Information

Note: Physician, if this section is blank, please complete.

Initial Certification Date _____   Revised Certification Date _____

Estimated length of need (number of months) _____
1 – 99 (99 = Lifetime)

Diagnosis codes (ICD-10) – separate with a comma:

_____

_____

_____

Yes	No	
☐	☐	Does the patient have a malignant tumor with obstruction of the lymphatic drainage of extremity?
☐	☐	Has the patient had surgery or radiation that interrupted normal lymphatic drainage or is there a congenital adnormality of lymphatic drainage?
☐	☐	Is the device prescribed for the treatment of chronic venous insufficiency with edema and/or venous ulcers?
☐	☐	Is there intractable lymphedema?

What has the physician prescribed as the pressures to be used?

_____

Frequency: _____

Duration of use of this device: _____

Please continue on the next page.

Section 3 – Physician Attestation and Signature

I certify that I am the physician identified in section 1C of this form. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge.

Your signature required

_____   _____ _____ _____

Physician's Signature (Signature and date stamps are not acceptable)   Date Signed