CERTIFICATE OF MEDICAL NECESSITY

This form is to certify medical necessity for durable medical equipment (DME) for a patient.

Sponsor SSN (XXX-XX-XXXX): ______________ or DoD Benefits Number (DBN) (XXXXXXXXX - XX): ______________

Patient Name: ____________________________ Patient Date of Birth (MM/DD/YYYY): ___________

If applicable, Patient SSN (XXX-XX-XXXX): ______________ or DBN (XXXXXXXXX – XX): ______________

Provider Name: ____________________________ Provider Tax Identification Number (TIN): ______________________

Claim Internal Control Number (ICN) (if available): ____

Diagnosis code(s): ____

Is the DME item a: CPAP device breast pump or breastfeeding supplies

If a CPAP device please provide the O2 levels so the device can be properly set. ____________

If a breast pump/breastfeeding supplies indicate:

the number of weeks (gestational age): __________ and corresponding diagnosis code: __________

HCPCS/CPT Code	Description	Quantity	Notes

Additional information: Please provide supporting information that will assist with processing this request.

____

____

Length of need: ____

Start date (MM/DD/YYYY): __________ End date (MM/DD/YYYY): __________

Authorization

____ ____________________

Physician Signature Date (MM/DD/YYYY)

Note: Capped rental items are covered for a 15-month period. If the Certificate of Medical Necessity (CMN) does not cover the entire rental period, another CMN will be required to process claims after the end date.

Submit Form

Fax this form to 877-989-0030 or mail the completed and signed form to:

TriWest TRICARE West Region
P.O. Box 202167
Florence, SC 29502-2167

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