Certificate of Medical Necessity

Patient Information:

Name:
Medicare Number:
Address:

Phone:

Prescribing Information

Diagnosis: ______________Breast Cancer/174.8 _____________Other/

Date of Surgery: Mastectomy: Right Left Both

Supplies Needed:

______SOFTEE® (Post Mastectomy Recovery Garment)
______Breast Prosthesis
______Surgical Bras

Refills: __________Lifetime

By signing below, I certify that all of the above information is true, and all items/supplies are Medically Necessary for this patient.

Physician Signature: ____ Date: ___________________

Medicare Provider Number: __________________________ UPIN Number: ________________________

Physician Name and Address:

Note to Medicare Beneficiary:
A signed copy of this form must be included when submitting a claim to Medicare for reimbursement. Keep copies for your file of all paperwork you are submitting.