Certificate of Medical Necessity

Form for supplies/medical equipment without specific CMN

BlueCross BlueShield of Kansas

Section 1A – Patient Information

CLEAR DATA

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | State | ZIP Code | +4 | County

Date of Birth | Height | Weight

Section 1B – Supplier Information

Supplier Name | Address

Phone Number | NPI Number | City

State | ZIP Code | +4 | County

Section 1C – Physician Information

First Name | MI | Address

Last Name | Suffix | City

Phone Number | ID Number | 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:

Give brief description of supply/medical equipment prescribed (attach additional sheet if needed):

Briefly list specific patient physical limitations/conditions pertinent to request (attach additional sheet if needed):

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