CENTRAL INDIANA PODIATRY PC
8651 Township Line Road
Indianapolis, In 46260-1578
317-931-0664
Fax 317-931-0797

CERTIFICATE OF MEDICAL NECESSITY

PATIENT NAME: _____ DOB: _____/_____/_____

ADDRESS: _____ PHONE: ( ) _____

_____ SEX: M F

_____

PRESCRIPTION DATE: _____/_____/_____ STAFF INITIALS: _____

PRIMARY MEDICAID PROVIDER: _____

INSURANCE COMPANY: _____ ID#_____

GROUP#_____ REFERRAL TYPE: SELF HPCS#_____

RELATED DIAGNOSIS WITH CODES:

DX: _____ CODE:_____DX:_____ CODE:_____

DX:_____ CODE:_____DX:_____ CODE:_____

PROGNOSIS: _____

REASON SUPPLIES AND/OR EQUIPMENT IS NECESSARY:

_____

_____

_____

DURATION NEEDED: _____

PRESCRIBING PROVIDER'S NAME: _____
(PLEASE PRINT)

PROVIDER'S SIGNATURE: _____