TRSCARE

Fax: (281)602-5094
Email: hello@trscare.org

Physician Certification of Medical Necessity

Date: ____________________

Patient Information

Name: ______________________________ DOB: ____________________

Phone: ____________________ Email: ______________________________

Address: ______________________________ City, State, Zip: ____________________

Insurance: ____________________ ID#: ____________________ Group#: ____________________

☐	HCPCS Code and Product	Qty	Diagnosis Code	Length of Need
☑	**A9282** Cranial Prosthesis/Wig	1	C ____________________ *(Cancer Code)* L ____________________ *(Alopecia Code)*	1 year

Physician Information

Facility Name: ______________________________ NPI: ____________________

Address: ______________________________ City, State, Zip: ____________________

Physician Name: ______________________________ Physician Phone #: ____________________

Physician Signature: ______________________________ Date: ____________________

Please return completed RX by email to hello@trscare.org or by fax to (281)602-5094.

www.trscare.org

Revised: 01/26/2022