Allergy Buyers Club

Medical Reimbursement Form

Please print this form, have your doctor fill it out, and send it directly to your insurance provider along with a copy of your invoice showing product purchase.

Certificate of Medical Necessity

A requirement of your patient's health insurance and/or the Board of Equalization

Patient Name: _____ DOB:_____ Prescription Date: _____

Address & Phone: Sex: M_____ F_____ Initial _____

_____ Renewal _____

_____ HIC#:_____

Insurance Company (s):
#1_____
#2_____

Policy/Group # (s):
#1_____
#2_____

Medical supplies and/or equipment will be needed for _____ months from the above date.

Related Diagnosis with applicable diagnosis code (s):

_____

_____

Reason supplies and/or equipment is necessary:

_____

_____

Billing Code:	Required Medical Items (if necessary, list additional items on back)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: Use billing code HCPCS-E1399 Durable Medical Equipment (DME), Miscellaneous.

Prognosis: _____ Date last seen PRIOR to this prescription: _____

Physician's Name: _____ Phone Number: _____

Complete Address: _____

Medi-Cal Provider #: _____ Unique Physician ID Number (UPIN) _____

Physician's signature: _____ Date: _____