



Certificate of Medical Necessity Sphigmomanometer

Section A Certification Type/Date Initial ___/___/___ Revised ___/___/___

Patient Name: _____ Customer ID #: _____

Address: _____ Physician Name: _____

Telephone: _____ Telephone: _____

Section B

Est. Length of need (# of months) _____ Diagnosis _____

Answers _____ (Circle **Y** for Yes, **N** for No, or **D** for Does not Apply)

Y N D Does the patient has a diagnosis of Uncontrolled Hypertension (over 140/90mmHg) despite medication therapy?

Y N D Is the patient is on two or more medications for hypertension?

Y N D Does the patient has comorbidities such as: Coronary Artery Disease, Renal Insufficiency, History of Miocardial Infarction, Diabetes?

Y N D Has the patient being recently diagnosed? (last month)

Y N D Is patient bedridden or from a "Hogar"?

Patient must meet at least two of the above criteria (Section B) to be elegendible for the benefit.

Sphigmomanometer Benefit Description: The purpose of this benefit is to offer alternative to monitor blood pressure and assistance for physicians in the treatment and management of Hypertension. Will also provide general education on adequate utilization of device and benefits of self monitoring and communicating to PCP results.

Section C

Y N D _____ Is patient bedridden or from a "Hogar"?

Physician Comments:

Section D Physician Attestation and Signature/ Date

I Certify the medical necessity for the service requested and that the information above is true, accurate and complete, to the best of my knowledge.

Physicians Signature _____

Date ___/___/___ Lic. #: _____