DURABLE MEDICAL EQUIPMENT (DME)
CERTIFICATE OF MEDICAL NECESSITY

This form is for prior authorization of durable medical equipment only. **ALL APPROVALS AUTHORIZED THROUGH THE USE OF THIS FORM ARE SUBJECT TO THE ENROLLEE'S BENEFITS AND ELIGIBILITY.**

Please fax to Case Management:
Central Virginia/Fredericksburg/Western – (804) 819-5186 *or* toll free (866) 284-1057
Tidewater – (757) 466-1133
Roanoke/Danville/Lynchburg – (540) 344-8007 *or* toll free (800) 827-7192

________________________________ Patient's Date of Birth: _____/_____/_____
Patient's Name

Patient's ID# ________________________

____
Patient's Address

________________________________ ________________________________
City, State, Zip Code Telephone Number

Type of Equipment/Supply/Appliance: ____

Please describe the patient's condition that warrants the requested equipment (include the ICD-9 code):

____

____

What other treatment modalities have been tried in the past?

____

What are your expected goals or outcomes for the patient?

____

How long will the patient need the equipment/supply/appliance?

____

Name/Phone Number of Preferred DME Vendor: __________________________ Phone #: ______________

This Certificate of Medical Necessity has been sent to preferred DME Provider? ☐ ***Yes*** ☐ ***No***

Name of Ordering Physician: ________________________________ Telephone Number: ________________

Physician's Address: ____

Physician's Signature: __________________________________ Date: ________________________________

Central VA/Fredericksburg/Western: PO Box 5307, Richmond, Virginia 23220 (804) 819-5151 *or* (800) 727-7536
Tidewater: PO Box 62347, Virginia Beach, Virginia 23466 (757) 461-0064 *or* (800) 828-7989
Roanoke: PO Box 1751, Roanoke, Virginia 24008 (540) 344-8838 *or* (888) 338-4579