Medical Necessity Form

Employer: _____

Name: _____ Tel.# _____

Address: _____

Medical Necessity Statement

Complete this section if, the patient has a diagnosed medical condition and that the treatment, product or medicine (e.g. dual purpose or over-the-counter items) relates to the treatment of the medical condition.

The following information is being provided to substantiate a "medical necessity" for the person named and the product or service named below:

Patient's Name: _____

Specify Product or Service: _____

The above patient has been diagnosed with a medical condition and this product/service is prescribed by me to treat this medical condition. Furthermore, the product/service is a medical necessity rather than to promote good health and/or is not cosmetic in nature.

Provider's Signature: _____ *Date:* _____

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