

Advanced Medical Supply
3322 N. Milwaukee Avenue, Chicago, IL 60641
Phone: (773) 205-6993 Fax: (773) 205-6994

CERTIFICATE OF MEDICAL NECESSITY

Patient Name: LOUISE MOLFESE (F)

DOB: 06/01/1932 HEALTH INSURANCE CLAIM No: XOG901841855

Address: 2640 N Sheffield Apart. 701 Chicago, IL 60614

Phone: (773) 317-8912

Rx

PRODUCT DESCRIPTION	QUANTITY
Pull ups/Diapers	200
Liners	120
Underpads	150
Gloves	200

Height: _____

Weight: _____ lbs

REFILLS: 11

DIAGNOSES:

- | | | |
|---|---|--|
| <input type="checkbox"/> Stress incontinence (female) (male) | <input type="checkbox"/> Fecal smearing | <input type="checkbox"/> Emphysema/COPD/Asthma |
| <input type="checkbox"/> Urge incontinence | <input type="checkbox"/> Fecal urgency | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Incontinence without sensory awareness | <input type="checkbox"/> Full incontinence of feces | <input type="checkbox"/> Diabetes Mellitus |
| <input type="checkbox"/> Post-void dribbling | <input type="checkbox"/> Drug induced retention of urine | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Nocturnal enuresis | <input type="checkbox"/> Other retention of urine | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Continuous leakage | <input type="checkbox"/> Retention of urine, unspecified | <input type="checkbox"/> Dysphagia |
| <input type="checkbox"/> Unspecified urinary incontinence | <input type="checkbox"/> Feeling of incomplete bladder emptying | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Mixed incontinence | <input type="checkbox"/> Generalized Body Weakness | <input type="checkbox"/> Debility |
| <input type="checkbox"/> Overflow incontinence | <input type="checkbox"/> Degenerative Osteoarthritis of _____ | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Other specified urinary incontinence | <input type="checkbox"/> Autistic Disorder | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Incomplete defecation | <input type="checkbox"/> Organic Brain Syndrome | <input type="checkbox"/> HTN |

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this Patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

DOCTOR'S INFORMATION

Doctor's Signature: _____ Date: _____
Print Name: _____ NPI#: _____
Facility Name: _____
Address: _____
Phone: _____ Fax: _____