UNLOCKING ACCESS
Motion made possible

PROVIDER CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION

Full Name:	Phone Number:
Date of Birth:	Email:
Address:	

PROVIDER INFORMATION

Provider Name & Title:	
Practice / Facility Name:	
Email:	Phone Number:

MEDICAL INFORMATION

- Primary Diagnosis: _____
- Secondary Diagnosis (if applicable): _____

Please describe the patient's condition and functional limitations that create the need for the requested equipment:

REQUESTED EQUIPMENT

- Equipment Name/Description _____
- Quantity: _____
- Expected Length of Need: ☐ Temporary ☐ Long Term ☐ Lifetime

How will this equipment improve the patient's safety, mobility, independence, or quality of life?

STATEMENT OF MEDICAL NECESSITY

I certify that the equipment listed above is medically necessary for the patient named on this form and is required due to the patient's medical condition and functional limitations. The equipment is reasonable, appropriate, and essential for the patient's care.

Provider Signature _____

Date: _____