Form Approved
OMB No. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY
CMS-846 — PNEUMATIC COMPRESSION DEVICES

DME MAC 04.04B

SECTION A **Certification Type/Date: INITIAL** ___ ___ ___ **REVISED** ___ ___ ___ **RECERTIFICATION** ___ ___ ___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
HICN _____	Borbas Pharmacy 2046 Bath Avenue Brooklyn, NY 11214 7186779066 NSC or NPI # 1801926019

PLACE OF SERVICE_____	HCPCS CODE	PT DOB Sex ____ (M/F) Ht. ____(in) Wt ____(lbs.)
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN UPIN or NPI #_____

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 *(99=LIFETIME)* | DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–5 FOR PNEUMATIC COMPRESSION DEVICES (Circle Y for Yes, N for No, Unless Otherwise Noted)
Y N	1. Does the patient have chronic venous insufficiency with venous stasis ulcers?
Y N	2. If the patient has venous stasis ulcers, have you seen the patient regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?
Y N	3. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?
Y N	4. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?
Y N	5. Has the patient had lymphedema since childhood or adolescence?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____TITLE: _____EMPLOYER:_____

SECTION C **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D **PHYSICIAN Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE _____/_____/_____