Prescribing Physician's Statement of Medical Necessity

My Biliblanket, Inc.
16220 S. Frederick Rd, Suite 500
Gaithersburg, MD 20877
Ph: 202.558.0219 / Fax: 1.866.901.1201

PATIENT INFORMATION:

PATIENT NAME: ____________________

PATIENT ADDRESS: ____________________

CITY: ____________________ **STATE/ZIP:** ____________________

BIRTH WEIGHT: ____________________ **CURRENT BILIRUBIN LEVEL:** __________

DOB: ____________________

DX: ____________________ **ICD-9:** ____________________

Prognosis: ____________________

Description	Purchase/Rental	Length Of Need
BILI-BLANKET FOR DAILY USE	Daily Rental	__________

Medical Justification: ____________________

____

I, the undersigned physician, certify that the above prescribed equipment is medically necessary for this patient. The use of this equipment is reasonable and necessary, and not being prescribed as an equipment for convenience.

Physician Name: ____________________

Physician Signature: ____________________

Date: ____________________

NPI # ____________________