STATEMENT OF MEDICAL NECESSITY
(Please type or print legibly)

Rev 10-01-05

Patient's Name: _____ Social Security No: _____

Date of Birth: _____

- What is the service or item(s) being prescribed? _____

_____

_____

_____

- What are the customary charges for this service or item(s)? _____

_____

- What is the medical reason for the service or item(s)? (Please be specific. Include information on other treatment options which have been unsuccessful.)

_____

_____

_____

_____

_____

- What is the quantity/frequency and for what duration is the service or item(s) needed?

_____

_____

_____

Provider's Name: _____

Address: _____

Telephone: _____

_____ _____

Prescribing Practitioner's Signature Date

If you have any questions, please call the caseworker _____

at _____ ; or the case manager _____

at _____ .