

Effective 10/01/95

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 02.02A

Certificate Of Medical Necessity: **MOTORIZED WHEELCHAIRS**

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PATIENT NAME: \_\_\_\_\_ HICN: \_\_\_\_\_

**SECTION C** Confirmation Of Physician Order / Narrative Description Of Equipment And Cost

- (1) Narrative diagnoses given by physician; (2) Narrative description of all items, accessories and options ordered;  
 (3) Supplier's charge; and (4) Medicare Fee Schedule Allowance for each item, accessory, and option.

*(See Instructions On Back)***SECTION D** Physician Attestation and Signature/Date

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

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)