*"Your National Diabetic Supplier"*

**19 South Dixie Highway**
**Lake Worth, FL 33460**
**(800) 920-0411**
**(800) 572-8886 FAX**

# Certificate of Medical Necessity
# For Ostomy Supplies

Patient Name:
Patient Address: D.O.B:

Please indicate last date the patient was seen:_____

ICD-9 Code for Ostomy Patient (please circle): V44.2 V44.3 V44.6

V55.2 V55.3 V55.6

Type of Procedure:_____

Supplies Ordered: Required Medical Items

Convatec _____

Holliser _____

Other_____ _____

Physicians Information:

Physicians Name
Physicians Address
Phone
Fax

I certify that I am treating this patient and the information provided is accurate.

Date:_____ UPIN#:_____

_____
Signature