Form Approved
OMB No. 0938-0679

DME 11.02

CERTIFICATE OF MEDICAL NECESSITY
CMS-854 — CONTINUATION FORM

PATIENT NAME	PATIENT HICN

SECTION C Narrative Description of Equipment and Cost (continued)

(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.)

Qt	Manufact	Model	Part Number	Description	Code	Modifier	Billed	Allowable

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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.