



BlueCrossBlueShield
of Mississippi

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI DURABLE MEDICAL EQUIPMENT CERTIFICATION FORM

It's good to be Blue.

**(THIS FORM MUST BE COMPLETED BY THE PHYSICIAN PRESCRIBING THE EQUIPMENT
AND ATTACHED TO THE CLAIM FILED BY THE SUPPLIER.)**

PATIENT'S NAME: _____ CONTRACT #: _____

EQUIPMENT PRESCRIBED: _____ CPT CODE: _____

DESCRIPTION: _____

HOW LONG WILL PATIENT NEED EQUIPMENT?: _____

DATE PRESCRIBED: _____ DIAGNOSIS: _____

ICD9 OR ICD10: _____ DESCRIPTION: _____

BRIEF HISTORY OF PATIENT: _____

IF THE EQUIPMENT IS FOR NEONATAL JAUNDICE, PLEASE INCLUDE THE FOLLOWING INFORMATION:

PRE-TREATMENT SERUM BILIRUBIN LEVEL: _____

IF THE EQUIPMENT IS FOR OXYGEN/OXYGEN SUPPLIES, PLEASE INCLUDE THE FOLLOWING INFORMATION:

FREQUENCY OF USE? _____

DATE & RESULT OF LAST OXYGEN LEVELS ON ROOM AIR: _____

IF THE EQUIPMENT IS FOR C-PAP/BI-PAP, PLEASE INCLUDE THE FOLLOWING INFORMATION:

LOCATION AND NAME OF SLEEP STUDY FACILITY: _____

DATE OF SERVICE FOR SLEEP STUDY: _____

RDI ORIGINAL STUDY: _____

IF THE EQUIPMENT IS FOR THE HOME BLOOD GLUCOSE MONITORING SYSTEM, PLEASE PROVIDE THE FOLLOWING INFORMATION:

IS THE PATIENT TAKING INSULIN? _____

IF THE EQUIPMENT IS FOR THE INSULIN PUMP SYSTEM, PLEASE PROVIDE THE FOLLOWING INFORMATION:

IS THE PATIENT TAKING INSULIN? _____ FREQUENCY: _____

DEGREE OF DIABETIC CONTROL: _____

PHYSICIAN'S NAME: _____ TELEPHONE #: _____

(Please Print)

PHYSICIAN'S COMPLETE ADDRESS: _____

PHYSICIAN'S SIGNATURE: _____

DATE: _____