Certificate of Medical Necessity (CMN)

Sponsor ID: _____ Patient date of birth: _____

Patient name: _____

Provider name: _____ Tax Identification Number (TIN): _____

Claim Internal Control Number (ICN) (if available): _____

Diagnosis code(s): _____

Is the DME item a CPAP device? If yes, please provide the O2 levels so the device can be properly set: _____

Is the DME item a breast pump or breastfeeding supplies? ☐ Yes ☐ No

If yes, please indicate the number of weeks (gestational age) and corresponding diagnosis code: _____ _____

HCPCS/CPT Code	Description	Quantity	Notes

Additional information: _____

_____

_____

_____

Length of need: _____ Start date: _____ End date: _____

Physician signature: _____ Date: _____

Note: Capped rental items are covered for a 15-month period. If the CMN being submitted does not cover the entire rental period, another CMN will be required in order to process claims after the end date.

Fax form to: (608) 221-7542

Humana Military | TRICARE®