



**Your SinuPulse Elite® Purchase
May be Insurance Reimbursable!**

Please print this form, have your doctor fill it out, and send it directly to your insurance provider along with a copy of your invoice showing product purchase.

Certificate of Medical Necessity

A requirement of your patient's health insurance and/or the Board of Equalization
(Requires Physician's signature)

Patient Name _____ Date of Birth _____ M F

Street Address _____ City _____ State _____ Zip _____ Phone _____

Insurance Companies(s) _____ Policy/Group Number(s) _____
#1 _____
#2 _____

Prescription Date _____ Renewal _____ HIC# _____ Initial _____

Diagnosis Code _____ Diagnosis (if necessary, list additional items on back) _____

Chronic Sinusitis 473.9 - Chronic Rhinitis 472.0 - Post-op 92024 - Anosmia 781.1 - Chronic Tonsillitis 474.0 - Allergic Rhinitis 477.9

Reason why products are necessary:

Billing Code _____ Required Medical Items _____
HCPCS-E1399 Durable Medical Equipment, Miscellaneous SinuPulse® Elite Nasal Sinus Irrigation System

Physician Information

Physician's Name _____ Phone Number _____
Patient's Prognosis _____ Date last seen PRIOR to this prescription _____
Street Address _____ City _____ State _____ Zip _____
Medi-Cal Provider Number _____ Unique Physician ID Number (UPIN) _____
Physician's Signature _____ Date _____