Your SinuPulse Elite® Purchase
May be Insurance Reimburseable!

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 patientís 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 Tonsilitis 474.0 - Allergic Rhinitis 477.9

Reason why products are necessary:

____

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

Physician Information

Physicianís Name ____________ Phone Number ____________

Patientís Prognosis ____________ Date last seen PRIOR to this prescription ____________

Street Address ____ City ____ State ____ Zip ____

Medi-Cal Provider Number ____________ Unique Physician ID Number (UPIN) ____________

Physicianís Signature ____________ Date ____________

Form CMN0910