Virginia Head and Neck Therapeutics, Inc.

10149 Bon Air Crest Dr.
Richmond, VA, 23235

Certificate of Medical Necessity

Patient Name, Address, Telephone and HICN

(_ _ _) _ _ _-_ _ _ _ HINC:_____

Supplier Name, Address, Telephone and NSC or NPI#

(_ _ _) _ _ _-_ _ _ _ NSC or NPI #:_____

PT DOB ___/___/____; Sex:_____ ; HT._____ ; WT. _____ (lbs)

Place of Service _____ Name and address of facility if applicable	HCPCS CODE _____ _____ _____ _____ _____	Physician's name, Address (printed/typed) Physician's NSC or NPI #:_____ Physician's Telephone #: (_ _ _) _ _ _- _ _ _ _

SECTION B: Information in this section may not by the supplier of the items/supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99(99=LIFETIME)	Diagnosis Codes: _____ _____ _____

Answers	**Answer questions 1-2 for initial evaluation** **Answer questions 3-4 for follow up evaluation (recertification)** Circle **Y** for **YES, N** for **NO, D** for **DOES NOT APPLY**
Y / N / D	1. Is the device being ordered for the treatment of Xerostomia?
___/___/_____	2. Enter the date of the initial consultation.
___/___/_____	3. Enter the date of the follow up face to face consultation.
Y / N / D	4. Did the patient demonstrate/report improvement in symptoms of xerostomia?

Name of person answering these questions if other than the Physician/Dentist (Please Print)
Name:_____ Title:_____ Employer:

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SECTION C: NARRATIVE DESCRIPTION OF EQUIPMENT AND COST

(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.

SECTION D: PHYSICIAN ATTESTATION AND SIGNATURE/DATE:
I certify that I am the Physician/Dentist 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 or fact in that section may subject me to civil or criminal liability.

Physician/Dentist's Signature_____ Date: ___ /___ / _____
(Stamps not acceptable)