



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

(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: \_\_\_\_\_ 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: \_\_\_\_\_