Prescribing Physician's Statement of Medical Necessity
My Biliblanket, Inc.
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Gaithersburg, MD 20878
Phone: 202.731.4375/ Fax: 1.301.947.9548

PATIENT INFORMATION:

PATIENT NAME: _____

PATIENT ADDRESS: _____

CITY:_____ **STATE/ZIP:** _____

BIRTH WEIGHT: _____ **CURRENT BILIRUBIN LEVEL:** _____

DOB: _____

DX:_____**ICD-9:**_____

Prognosis: _____

Description	**Purchase/Rental**	**Length Of Need**
BILI-BLANKET FOR DAILY USE	Daily Rental	_____

Medical Justification: _____

_____

I, the undersigned physician, certify that the above prescribed equipment is medically necessary for this patient. The use of this equipment is reasonable and necessary, and not being prescribed as an equipment for convenience.

Physician Name: _____

Physician Signature: _____

Date: _____

NPI # _____