

PurerAirPro.com

**PARADISE DISTRIBUTING INCORPORATED TOLL FREE 800-324-4454
901 SERVICE ROAD EFFORT PA 18330**

MEDICAL REIMBURSEMENT FORM

ASTHMA, ALLERGY AND RELATED CONDITION SUFFERERS.

HAVE YOUR HEALTH CARE PROFESSIONAL (DOCTOR) FILL THIS FORM OUT COMPLETELY, AND SEND THE SIGNED CERTIFICATE, ALONG WITH YOUR ONLINE PRODUCT INVOICE, TO YOUR INSURANCE PROVIDER FOR A POSSIBLE REIMBURSEMENT.

CERTIFICATE OF MEDICAL NECESSITY

A REQUIREMENT OF YOUR PATIENT'S HEALTH INSURANCE AND/OR BOARD OF EQUALIZATION

PATIENT NAME: _____

DATE OF BIRTH: _____ SEX: M F

ADDRESS: _____

TELEPHONE: _____ CELL PHONE _____

PRESCRIPTION DATE: _____ RENEWAL HIC#: _____

INITIAL: _____

INSURANCE COMPANY(S) POLICY/GROUP NUMBER(S)

1. _____

2. _____

DIAGNOSIS CODE DIAGNOSIS (IF NECESSARY, LIST ADDITIONAL ITEMS ON THE BACK OF THIS FORM.)

REASON WHY THE AIR PURIFICATION SYSTEM(S) ARE NECESSARY:

BILLING CODE REQUIRED MEDICAL ITEMS (IF NECESSARY, LIST ADDITIONAL ITEMS ON THE BACK OF THIS FORM.)

NOTE: USE BILLING CODE HCPCS-E1399

DURABLE MEDICAL EQUIPMENT (DME), MISCELLANEOUS

DOCTOR'S NAME: _____

TELEPHONE NUMBER(S): _____

STREET ADDRESS: _____

STATE _____ ZIP CODE _____

UNIQUE DOCTOR'S ID NUMBER: _____

PATIENT PROGNOSIS: _____

DATE LAST SEEN PRIOR TO THIS PRESCRIPTION: _____

DOCTOR'S SIGNATURE: _____

DATE OF PRESCRIPTION: _____