BMU

BRYAN MUNICIPAL UTILITIES

Reliable. Local. Yours.

Medical Certification Program

Part 1—to be completed by Customer

Account No. _____

Customer Name:_____

Customer Signature:

_____

Relationship to Patient:_____

Patient's Permanent address:

_____

Telephone Number:_____

Part 2—The following is to be completed by a licensed medical professional and only after you, or someone in your office, has examined the individual whose name appears as the patient on the form below:

I certify, that to the best of my knowledge, the information below is true.

The following individual has a medical necessity for life-sustaining equipment:

Patient Name:_____

Date of Birth: _____

Pertinent Diagnosis _____

_____

_____

_____

_____

_____

Part 2 - Continued

Qualifying Equipment (electrical equipment in-home usage):

____ Oxygen Concentrator
____ Oxygen Monitors
____ Suction Machine
____ Dialysis (In Home)
____ Ventilator
____ Feeding Pump
____ Respirator

Other: _____

_____

(CPAP machines & nebulizers are not considered life sustaining equipment)

Estimated Length of Need _____
(recertification required every 90 days)

I certify that I advised my patient that disclosure of the requested information may be subject to redisclosure by the recipient and no longer be protected by the HIPAA rules and regulations.

Physician Signature: _____

Physician Name: _____

License/Certification Number:

_____

Address: _____

City, State, Zip: _____

Telephone No.: _____

I understand and give permission to BMU to contact, for verification, the physician who completed the information on this form.

Patient/Guardian Signature:

_____