TRIPLE-S ADVANTAGE

# Certificate of Medical Necessity
## Sphygmomanometer

**Section A:** General Information — Certification: Initial: Revised:____/____/____

| | |
|---|---|
| Patient Name: | Customer ID #: |
| Address: | Physician Name: |
| Telephone: | NPI: |

**Section B:** Eligibility Criteria

| Est. Length of need (# of months): | Diagnosis Codes: |
|---|---|
| | |

| **Answers** | (Circle **Y** for Yes, **N** for No, or **D** for Does not Apply) |
|---|---|
| Y☐N☐D☐ | Does the patient have a diagnosis of Uncontrolled Hypertension (over140/90mmHg) despite medication therapy? |
| Y☐N☐D☐ | Is the patient is on two or more medications for hypertension? |
| Y☐N☐D☐ | Does the patient have comorbidities such as: Coronary Artery Disease, Renal Insufficiency, History of Myocardial Infarction, and Diabetes? |
| Y☐N☐D☐ | Has the patient being recently diagnosed? (last month) |
| Y☐N☐D☐ | Is patient bedridden or from a "Hogar"? |

**Patient must meet at least two of the above criteria (Section B) to be eligible for the benefit.**

**Sphygmomanometer Benefit Description: The purpose of this benefit is to offer alternative to monitor blood pressure and assistance for physicians in the treatment and management of Hypertension. Will also provide general education on adequate utilization of device and benefits of self-monitoring and communicating to PCP results.**

**Section C:** Physician Comments:

**Section D:** Physician Attestation and Signature/Date

I certify the medical necessity for the service requested and that the information above is true, accurate and complete, to the best of my knowledge.

Physicians Signature_____

Date: _____/_____/_____ Lic. #:_____
Month Day Year

***Rev. 8/2018***