Ahead of Beauty
Submittials@aheadofbeauty.org
509-426-4101
Fax: 1-866-635-0615

Date: _____

Physician Verification of Medical Necessity

Patient Information	
Name:	DOB:
Phone:	Email:
Address:	City, State & Zip
Insurance:	
ID#:	Group#:
Insurance Allowable:	Co-Pay:

	HCPCS Code & Product	Qty	Diagnosis Code	Length of Need
☐ ☐ ☐	A9282 Cranial prosthesis L8499 Unlisted procedure for misc. prosthetic services. A6250 Skin protectant, any type, any size	1	C _____ (Oncology code) L _____ (Dermatology code)	1 Year
Pre-Authorization#:				

PLEASE CHECK ONLY ONE BOX

- o The above recipient has damaged scalp or intact skin exposed to discomfort due to prescribed drugs and/or treatment deemed medically necessary.
- o The above recipient has damaged scalp or intact skin exposed to discomfort within the last six months due to prescribed drugs and/or treatment deemed medically necessary.
- o The above recipient has damaged scalp or intact skin exposed to discomfort within the last year due to a medical condition and is currently suffering.

Physician Information	
Facility Name:	NPI#:
Address:	City, State & Zip:
Physician Name:	Physician Phone:
This referral covers the application process for (1) no cost device provided through an Ahead of Beauty ** *Any written or typed modification to this Application/Verification voids this application/Verification entirely.*	
Physician Signature	
Date:	

Please return completed form to Submittials@aheadofbeauty.org OR Fax to 1-866-635-0615