Email: Submittials@aheadofbeauty.org

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	1	C _____ (Cancer code) L _____ (Alopecia code)	1 Year
Pre-Authorization#:				

PLEASE CHECK ONLY ONE BOX

- The above recipient will be suffering hair loss due to cancer drugs and/or treatment.
- The above recipient has suffered hair loss within the last six months due to cancer drugs and/or treatment.
- The above recipient has suffered hair loss within the last year due to a medical condition and is currently suffering from alopecia directly.

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