



Certificate of Medical Necessity

Patient Information

Patient Name: _____ DOB: _____

Patient Phone: _____ Referring Provider: _____

(1), (2), and (3) In This Section Must be Completed to Ensure Coverage

01. ☐ Angina: Class III or IV (CCS) *Class III defined as symptomatic at 1-2 city blocks
OR

☐ AHA Angina Equivalency: III or IV (CCS)

_____ Shortness of Breath with Exertion

_____ Limitations with Activities of Daily Living

_____ Need Nitroglycerin PRN

_____ Fatigue

02. ☐ Not Easily Amenable for Surgical Intervention/High Risk

OR

☐ Patient is Unwilling to Undergo Invasive Procedure

03. ☐ Diagnosed with Coronary Artery Disease (CAD, ASCVD)

_____ Obstructive Disease

_____ Non-Obstructive Disease (INOCA)

☐ Long COVID

Evaluate & Treat with EECF Therapy + Lifestyle Management

Physician Signature: _____ Date: _____

In making this referral, referring physician certifies that prescribed procedure is of medical necessity.

Please Email or Fax the Available Supporting Documents:

- Patient Demographic / Insurance Sheet
- Recent Physician Notes / Last Office Visit
- Cardiac Catheterization Reports
- Recent Hospitalization Discharge
- Nuclear Report
- Echocardiogram Report