

Certificate of Medical Necessity FLOWTHERAPY.COM

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Patient Information
Patient Name: DOB: Patient Phone: Referring Provider:
(1),(2), and (3) In This Section Must be Completed to Ensure Coverage
O1. 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
O2. Not Easily Amenable for Surgical Intervention/High Risk or Patient is Unwilling to Undergo Invasive Procedure
O3. Diagnosed with Coronary Artery Disease (CAD, ASCVD)
○ Long COVID
Evaluate & Treat with EECP 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