FLOW THERAPY

# Certificate of Medical Necessity

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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

**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 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