HI SIS

CERTIFICATE OF MEDICAL NECESSITY

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE	SUPPLIER NAME, ADDRESS, TELEPHONE and NPI #
(__ __ __) __ __ __ - __ __ __ __	HI SIS, LLC 800 South Beretaina, 250 Honolulu, HI 96815 (808) 381-8569 NPI #1639751480

PLACE OF SERVICE:	Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Gender _____
NAME and ADDRESS of FACILITY: **HI SIS, LLC** **800 South Beretaina , 250** **Honolulu, HI 96813**	17380: Electrolysis epilation, every 30 mins	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NIP # I am the above mentioned patient's **Primary Care Provider | Mental Health Provider.** (__ __ __) __ __ __ – __ __ __ __ NPI # _____

SECTION B: Certification

EST. LENGTH OF NEED (# OF MONTHS): **12**	DIAGNOSIS CODES: _____ _____ _____

	(Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
☐Hormone Therapy ☐Lived as gender ☐Both	Has patient received at least twelve (12) months of hormone therapy? and/or Has patient lived twelve (12) consecutive months as their gender identity
(# OF YEARS): _____ (# OF MONTHS):_____	Current number of years and/or months patient has received hormone therapy?
☐Y ☐N ☐D	Persistent, well-documented gender dysphoria *(please provide documentation)*
☐Y ☐N ☐D	Capacity to make a fully informed decision and to consent for treatment

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME_____ TITLE_____EMPLOYER_____

SECTION C: Narrative Description

please provide information related to the patient's gender dysphoria

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge.

PHYSICIAN'S SIGNATURE_____DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.