Certificate of Medical Necessity (COMN)

(Scheduled/Elective Admission)

Patient Name _____ MRN: _____

Attending Physician _____ Referring Physician: _____

Diagnosis _____ Date of Request _____

Clinic Contact Name/Phone#_____ CPT Code(s) _____

A. CLINICAL NECESSITY (Completed by Physician)

1. Are we providing a unique service not available in the patient's home community? Y N

2. Is the present problem one for which the patient is currently being treated within the University Healthcare system? Y N

3. How long has condition existed? _____

4. Is physician discounting services? Y N
   What percentage? _____

5. Extent of services needed
   - ❑ Medical Management (including Chemotherapy, Radiation Therapy)
   - ❑ Hospitalization
   - ❑ Diagnostic Testing
   - ❑ Surgical services
   - ❑ Other (explain) _____

Admitting Physician Approval _____ Date _____

B. FINANCIAL ASSESSMENT (Completed by Financial Counselor)

1. Has the financial assessment been completed? Y N

2. Is the patient a legal Utah resident? Y N
   If no, where are they from? _____

3. Does patient have outstanding debt with hospital or physician? Y N
   Balance due: _____
   Are repayment arrangements in place? Y N

4. Is patient eligible for any assistance program? Y N
   If yes, what source? _____

5. Estimated cost of services to be provided $ _____

6. Is patient able to make deposit greater than $150.00? Y N
   How much? _____

7. Recommendation: _____

Signature of Financial Counselor _____ Date _____

C. APPROVAL (Completed by Hospital Administrator)

COMN valid for 90 days from date of submission.

Medical Director Approval _____ Date _____

SOURCE: University of Utah Health Care, Salt Lake City.