

**Bureau for Medical Services  
Certificate of Medical Necessity  
Durable Medical Equipment/Medical Supplies**

**SECTION I**

**MEMBER DATA**

Medicaid ID# \_\_\_\_\_  
 Name \_\_\_\_\_  
 D.O.B. \_\_\_\_\_  
 Phone # (\_\_\_\_) \_\_\_\_\_

**SERVICING PROVIDER**

Provider ID# \_\_\_\_\_  
 Provider Name \_\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Phone # (\_\_\_\_) \_\_\_\_\_

**CMN Status**

\_\_\_\_\_ Initial  
 \_\_\_\_\_ Revised  
 \_\_\_\_\_ Renewed

**Section II MEMBER INFORMATION**

Answer all questions that are applicable to **DME/ Medical Supplies** services being requested. If answer is **Yes**. You must describe/ attach additional information to support medical justification.

- | DOES PATIENT:   | YES | NO  |
|---|-----|-----|
| 1. Have impaired mobility?  | ___ | ___ |
| 2. Have impaired endurance?   | ___ | ___ |
| 3. Have restricted activity?  | ___ | ___ |
| 4. Have skin break down? (Attach description of site, size, depth, and drainage)  | ___ | ___ |
| 5. Have impaired respiration? (Results of recent PO2/ saturation levels must be on file)                                    | ___ | ___ |
| 6. Require assistance with ADL'S ?  | ___ | ___ |
| 7. Have impaired speech?  | ___ | ___ |
| 8. Is item suitable for use in home and does the member/caregiver demonstrate willingness and ability to use the equipment? | ___ | ___ |
| 9. Height: _____ Weight: _____  |     |     |

**DATE PATIENT LAST EXAMINED BY PRACTITIONER:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<u>ICD 9- CODES</u>	<u>CLINICAL DIAGNOSIS</u>	<u>DATE OF ONSET</u>

**SECTION III**

Begin Service Date	HCPCS Code	Item Description	Estimated Length of Need (# Months)	Quantity and Frequency Of Use	Dollar Amount

**SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY**

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective", and is not a convenience item for the member, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. **(Must be completed, signed and dated by the Practitioner.)**

\_\_\_\_\_  
 Prescribing Practitioner's Name                      Practitioner's Signature                      Date                      ID #                      Phone #