CERTIFICATE OF MEDICAL NECESSITY
Cabinet for Health & Family Services
Department of Medicaid Service
Durable Medical Equipment

SECTION A Certification Type/Date INITIAL ____/____/____ REVISED
____/____/____

Patient Name, Address, Telephone and Member Number

(_____)_____-_____ Member # _____
_____

Supplier Name, Address, Telephone and ~~NSC~~ NPI Number

(_____)_____-_____ ~~NSC#~~
NPI :_____

Place of Service _____
Name and Address of Facility if Applicable
(See Reverse)

HCPCS CODE

PT DOB ____/____/____; Sex ____(M/F); HT. ____(in.); WT. ____(lbs.)

PRESCRIBER NAME, ADDRESS (Printed or Typed)

PRESCRIBER NPI:_____
PRESCRIBER TELEPHONE #: (_____)_____-_____

SECTION B PATIENT'S INFORMATION

(Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.)

Est. Length of Need (# of Months): _____ 1-99 (99=Lifetime)

DIAGNOSIS WITH CODES, PROGNOSIS, GENERAL CONDITION: _____
_____
_____
_____
_____

Type of equipment ordered: _____
_____

Duration of need: _____ month(s) Over 12 mos.: specify _____

Is patient confined to bed? No Yes - If yes, what % of the time is patient confined to the bed (circle one)? 50% 75% 100%

Is patient confined to the room? No Yes Ambulatory inside of home Ambulatory outside of home

Date patient last seen by the prescribing physician:
_____

Date equipment prescribed: _____

Is this equipment prescribed for use in the home? No Yes

Is patient disoriented? No Yes, occasionally Yes, most of the time

Is patient able to effectively and safely utilize equipment unassisted? No Yes

Name of person answering Section B questions, if other than physician (Please Print)

Name:_____ Title: _____ Employer:_____

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SECTION C	Narrative Description of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option.

SECTION D	Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). 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, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability

PHYSICIAN'S SIGNATURE _____ DATE ____/____/_____ (Signature And Date Stamps Are Not Acceptable)