MAP-1000B Rev. 7/10 **CERTIFICATE OF MEDICAL NECESSITY**

Cabinet for Health & Family Services

Department for Medicaid Services

Metabolic Formulas and Foods

Section A
Recipient Name: _____
MAID Number: _____
Recipient Address: _____
_____
_____
Phone Number: _____
Date of Birth: _____

Section B
Provider Name: _____
Provider Number: _____
Provider NPI: _____
Provider Address: _____
_____
_____
Phone Number: _____
Fax Number:

Section C Product prescribed:_____
_____
_____
_____
_____
_____
_____
_____

Section D
Prescriber Name: _____
Prescriber Number:_____
Prescriber NPI: _____
Prescriber Address: _____
_____
_____
Phone Number: _____
Fax Number: _____

Areas below must be completed by prescriber and not the supplier of the equipment/supply ordered.

Section E
Date of Request: _____
Initial CMN Request: _____ Date Last Seen by Prescriber: _____

Section F Primary Diagnosis: (Check applicable)
____Phenylketonuria____Hyperphenylalaninemia____Tyrosinemia (Types I, II, III)
____Branched-chain Amino-Acid Disturbance,specify:_____
____Urea Cycle Disorder, specify:_____
____Methylmalonic acidemia
____Other, please specify:_____
_____

Section G Pertinent medical history, diagnostic tests, treatment plan.
_____
_____
_____
_____
_____
_____
How often will the client be seen?_____Date therapy initiated: _____

Section H
I certify that I am the prescriber identified in Section A of this form. I have received Sections A, B, C, and D of the Certificate of Medical Necessity (including charges for items ordered). I certify that I or my medical staff has completed Sections E, F, and G. This CMN and any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section E, F, and G 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 printed
name:_____Signature:_____
Date signed:_____(Signature and date stamps are not acceptable.)