DELAWARE HEALTH AND SOCIAL SERVICES

Appendix B – Medicaid Certificate of Medical Necessity

General Instructions

- Incomplete or illegible forms will be returned and may delay the authorization process.
- Review the Delaware Medical Assistance Program manuals for instructions and form downloads at http://www.dmap.state.de.us/downloads/manuals.html

- Date Received: _____
- Date Eligible: _____
- Supporting Documentation ☐ YES ☐ NO
- TPL: ☐ YES-Type:_____ ☐ NO

FAX completed forms to: 302-255-4481 **Telephone: 302-255-9500**	DMMA Prior Authorization/Lewis Bldg 1901 N. DuPont Hwy.P.O. Box 906 New Castle, DE 19720	**Comments:**

A. PROVIDER INFORMATION

Name:	**FAX Number:**
Address:	
Contact Name:	**Telephone Number:**
NPI (Provider ID#):	**Taxonomy:**

B. CLIENT / PATIENT INFORMATION

Name:		**Medicaid ID#:**
Service Dates: **FROM:**	**TO:**	**Continuation of Service** ☐ **Yes** ☐ **No**
DOB:	**Diagnosis(es):**	

C. EQUIPMENT / SUPPLY(IES) (List additional items on "Continuation Form.")

HCPCS CODE	MOD	DESCRIPTION	TOTAL # OF UNITS	TOTAL U&C CHARGE

MOD(Modifier): Use "NU" for Purchase New, "UE" for Purchase Used, or "RR" for Rental;
Include Brand Name and Serial/Product Number as part of the description

EST. LENGTH OF NEED (# OF MONTHS):_____ 1-99 (99=LIFETIME)

D. PRACTITIONER AUTHORIZATION **IMPORTANT:** This section must be completed by the attending physician/practitioner.

Name (print)**:**	**Telephone Number:**
Address:	
Contact Name:	**FAX Number:**
NPI (Provider ID#):	
Signature:	**Date:**

I certify that the services described above are medically necessary for the identified patient/client.

DO NOT WRITE BELOW THIS LINE

Date Reviewed:	☐ **Approved** ☐ **Denied** ☐ **Incomplete**	**Authorization #:**
Signature:	Comments:	

DELAWARE HEALTH AND SOCIAL SERVICES

Appendix B – Continuation Form

CLIENT / PATIENT INFORMATION

Name:	**Medicaid ID#:**
Service Dates: **FROM:** **TO:**	

E. EQUIPMENT / SUPPLY(IES)

HCPCS CODE	MOD	DESCRIPTION	TOTAL # OF UNITS	TOTAL U&C CHARGE

PRACTITIONER AUTHORIZATION

IMPORTANT: This section must be completed by the attending physician/practitioner.

Name (print)**:**	**Telephone Number:**
Contact Name:	**FAX Number:**
Signature:	**Date:**

I certify that the services described above are medically necessary for the identified patient/client.