Example Only!!
#8-13 get completed
by physician

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: John Doe **Medicaid # (10 digits):** 1234567899

(2) DOB: 01/ 15/ 2010 **Sex:** M **HT:** 36" **(in) WT:** 45# **Date of Service:** ____/____/____

(3) Provider's name: Prentke Romich Company **Provider's DME #:** _____ **NPI #:** 1184602518

(4) Street address: 1022 Heyl Rd **City:** Wooster **State:** OH **Zip:** 44691 **Local telephone #:** 800-268-5224

(5) Provider's signature: _____ **Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:

Accent 1000 Dedicated, 84 location keyguard

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) F84.0 **Description(s):** Autism

F80.2 Mixed Expressive/Lang Disorder

_____ _____

(8) Indicate patient's ambulatory status while performing activities of daily living: ___Non-ambulatory ___Ambulatory, without assistance

___Ambulatory with the aid of a walker or cane, ____Ambulatory, with other assistance as described

Does the patient have decubitus ulcers? ___ Yes ___ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): _____

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

(9) For supplies, please indicate the dressing change required per day, week, month, etc.
N/A

Is additional information attached on separate sheet? _____Yes _____No (If "yes," enter recipient's name & I.D. Medicaid number on attachment

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(11) Please indicate the prescription date: _____

(12) Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN'S NAME:_____ PHYSICIAN'S NPI #:_____

PHYSICIAN'S SIGNATURE _____DATE___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.