VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES

SECTION I **INDIVIDUAL DATA** **SERVICING PROVIDER**

I.D. #		I.D. #	
Name		Name	
D.O.B.		Contact Person	
Phone #		Phone #	

Note: The CMN can now be used to meet the Face-to-Face requirements for applicable codes.

SECTION I **INDIVIDUAL INFORMATION**

Answer all questions that are applicable to DME service being requested. If answer is yes, you must describe/attach additional information.

DESCRIPTION/ADDITIONAL INFORMATION: (Additional space on reverse)

Does patient:	YES	NO
1. have impaired mobility?	☐	☐
2. have impaired endurance?	☐	☐
3. have restricted activity?	☐	☐
4. have skin breakdown? (Describe site, size, depth and drainage)	☐	☐
5. have impaired respiration? (Identify most recent PO_2_____/Saturation level _____ for patients on oxygen)	☐	☐
6. require assistance with ADL's?	☐	☐
7. have impaired speech?	☐	☐
*** 8. a) require nutritional supplements? (If yes, answer b and c below.)	☐	☐
b) sole source or primary source (circle one)		
c) height _____ weight _____		

FACE-TO-FACE COMPLETED YES☐ NO☐ N/A ☐

NAME/TITLE/ AND DATE OF PRACTITIONER WHO COMPLETED FACE-TO-FACE

IS THE ITEM SUITABLE FOR USE IN THE HOME AND DOES THE INDIVIDUAL/CAREGIVER DEMONSTRATE WILLINGNESS/ABILITY TO USE THE DME? YES☐NO☐

Date last examined by practitioner _____

ICD Code	Clinical Diagnoses	Date of Onset: Less than 6 months	Date of Onset: Greater than 6 months
		☐	☐
		☐	☐
		☐	☐
		☐	☐

SECTION III (ADDITIONAL SPACE ON REVERSE)

Begin Service Date	HCPCS Code	Item Ordered Description*	Length of Time Needed	Quantity Ordered/ x1 Month*	Frequency of Use* Justification/Comments/ Calories Per Day

SECTION IV **PRACTITIONER CERTIFICATION** (MUST BE SIGNED AND DATED BY THE PRACTITIONER)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PRACTITIONER NAME (print) | PRACTITIONER'S SIGNATURE* | DATE* | I.D.# | PHONE #

*Required fields. If any of these fields are blank the CMN is not valid. The other sections of the CMN can be documented on the CMN or in supporting documentation.
Practitioner's signature does not guarantee payment unless all documentation requirements are met.
Issuance of a PA does not guarantee payment. Payment is contingent upon all appropriate documentation being readily available for review.
Practioners who may complete the Face-to-Face are defined in 12VAC30-50-165 ***Complete diet order must be indicated in Section III

Ohio Department of Job and Family Services

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION SPEECH GENERATING DEVICE (SGD)

☐ **Repair** ☐ **Modification** ☐ **Upgrade**

Name of Provider	Prentke Romich Co
Provider NPI #	
Medicaid Legacy #	

Instructions: The Certificate of Medical Necessity (CMN) must be used for speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer		Billing Number
Funding Source of SGD	SGD is necessary to meet the consumer's basic communication needs. ☐ Yes ☐ No	Date of Birth
Make, model and Serial # of SGD (include PA # for purchase, if known)	Date Purchased	Are parts requested still under warranty? ☐ Yes ☐ No **Attach copy of warranty.**

Section A - Repair of SGD

Type of repair: ☐ Major ☐ Minor	Was this SGD purchased through Medicaid? ☐ Yes ☐ No

Description of required parts needed to complete repair. Include manufacturer price lists.

Part Code	Name of Part	Reason part needs to be replaced/repaired

Describe the nature of the damage to the SGD:

Section B - SGD Modifications (attach additional documentation, if needed.)

Consumer's initial condition

Current condition warranting modification

How will modification correct change in condition?

Section C - SGD Upgrade

Consumer's initial condition

Section C - SGD Upgrade (continued)

Current condition warranting upgrade

How will upgrade correct change in condition?

Speech-Language Pathologist (SLP) Attestation and Signature/Date

Name *(PRINTED)*

I certify that I am the SLP identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

SLP Signature	Date	License #

Prescriber Attestation and Signature/Date

Prescriber Name *(PRINTED)*

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber signature *(No stamps)*	Date	Medicaid Provider #