EXAMPLE ONLY

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

SECTION I INDIVIDUAL DATA

I.D. #		I.D. #	9135227
Name		Name	PRC-Saltillo
D.O.B.		Contact Person	Becky Trevino
Phone #		Phone #	800-268-1984

SERVICING PROVIDER

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.

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 _____		

DESCRIPTION/ADDITIONAL INFORMATION:
(Additional space on reverse)

<<<< all questions must be completed by the physician

FACE-TO-FACE COMPLETED YES☒ NO☐ N/A☐ List Date last seen here

NAME/TITLE/ AND DATE OF PRACTITIONER WHO COMPLETED FACE-TO-FACE List Dr. Name here

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 List Date last seen here

ICD Code	Clinical Diagnoses	Date of Onset: Less than 6 months	Date of Onset: Greater than 6 months
	Physician must complete entire section		
		☐	☐
		☐	☐
		☐	☐
		☐	☐

SECTION III (ADDITIONAL SPACE ON REVERSE)

Begin Service Date	HCPCS Code	Item Ordered Description* List equip, only-no color or specifics	Length of Time Needed	Quantity Ordered/ x1 Month*	Frequency of Use* Justification/Comments/ Calories Per Day
Leave	E2510	Accent 1000	5yr	1	Daily
These	E2599	Keyguard	5yr	1	Daily
Boxes	E2512	Mount	5yr	1	Daily
Blank					

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.

Dr's Printed Name	Dr's signature	Must have a date	Dr NPI number	
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