Return Form To: WVMI @ 3001 Chesterfield Place, Charleston, WV 25304
Fax # 304-346-8185 or 1-877-762-4338

WV Department of Health and Human Resources
Bureau for Medical Services – Certificate of Medical Necessity
Durable Medical Equipment, Prosthetics, Orthotics, Supplies and Home IV Infusion Therapy

Section I – Recipient Data	**Servicing Provider**	**CMN Status**
Id#_____	**Provider#**_____	_____**Initial**
Name_____	**Provider Name**_____	_____**Revised**
Address_____	**Contact Person**_____	_____**Renewed**
DOB_____	**Phone #** _____	

Section II_____ **Recipient Information**_____

Answer all questions that are applicable to DME/Prosthetics/Orthotics services being requested. If answer is YES, you must describe/attach additional information to support medical justification. (Additional Space on Page 2).

DOES PATIENT:	**YES**	**NO**
1. Have impaired mobility?	☐	☐
2. Have impaired endurance?	☐	☐
3. Have restricted activity?	☐	☐
4. Have skin break down? (Describe site, Size, Depth and Drainage on reverse side of form)	☐	☐
5. Have impaired respiration? (Identify most recent PO2/saturation level for PTS. On 02) (Room Air)	☐	☐
6. Require assistance with ADL's?	☐	☐
7. Have impaired speech?	☐	☐
8. Its item suitable for use in home and does the Patient/Caregiver demonstrate willingness and ability to use the equipment?	☐	☐

DATE PATIENT LAST EXAMINED BY PHYSICIAN: ____/____/____

FUNTIONAL LEVEL: (AS PER Medicare standard classification for specific prosthetic components) **Attach supporting documentation.**
Level-O **Level-I** **Level-II** **Level-III** **Level-IV**

ICD 9 – CODES	**CLINICAL DIAGNOSIS**	**DATE OF ONSET**

Section III (Additional space on page 2)

Begin Service Date	HCPCS Code	Item Ordered Description	Length of Time Needed	Quantity Ordered X 1 Mo	Quantity/Frequency of use Justification/Comments	Dollar Amount

Section IV **PHYSICIAN CERTIFICATION OF MEDICAL NECESSITY**

I certify that this patient meets the program eligibility criteria and that this equipment is a port of my course of treatment and is "Reasonable, Medical Necessary, and is most cost effective", and is not a convenience item for the recipient, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate.

(Must be completed, signed and dated by the Physician)

_____	_____	___/___/___	_____	_____
Ordering Physician's Name	**Physician's Signature**	**Date**	**ID#**	**Phone #**

Certificate of Medical Necessity Form – Continued

Recipient Name_____ **Recipient ID #**_____

Provider Name_____ **Provider ID #**_____

Section II – (Continued) Description / Additional Information

Section III – (Continued)

Begin Service Date	HCPCS Code	Item Ordered Description	Length of Time Needed	Quantity Ordered X 1 Mo	Quantity/Frequency of use Justification/Comments	Dollar Amount

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(Must be completed, signed and dated by the Physician)

_____ _____ __/__/__ _____ _____

Ordering Physician's Name **Physician's Signature** **Date** **ID#** **Phone #**