CERTIFICATE OF MEDICAL NECESSITY

Recipient Name:

EXPLANATION OF PROBLEM: Provide an explanation of the particular problem resulting from the diagnosis which relates to this prior authorization request.

PROGNOSIS:

HOW LONG IS THIS PROBLEM EXPECTED TO LAST?

☐ # of Months___ ☐ INDEFINITELY ☐ PERMANENTLY

I CERTIFY THAT THE INFORMATION GIVEN IN THIS FORM IS A TRUE AND ACCURATE MEDICAL INDICATION FOR THE PROCEDURE(S) REQUIRED. THERE IS NO OTHER EQUALLY EFFECTIVE TREATMENT AVAILABLE WHICH IS MORE CONSERVATIVE OR SUBSTANTIALLY LESS COSTLY (ARSD 67:16:01:06.02). ALL OTHER TREATMENT TO CORRECT THIS PROBLEM HAS BEEN EXHAUSTED.

PHYSICIAN'S NAME:

PHYSICIAN'S SIGNATURE **DATE**

Required for Nutritional Therapy requests only:

IS THIS THE INDIVIDUAL'S SOLE SOURCE OF NUTRITION? YES ☐ NO ☐

DOES THIS INDIVIDUAL RESIDE AT HOME? YES ☐ NO ☐

NUTRITION BEING PRESCIBED:

Required for Durable Medical Equipment requests only:

MEDICAL NECESSITY / JUSTIFICATION FOR PURCHASE OR CONTINUED RENTAL:

EQUIPMENT BEING PRESCRIBED:

EXPLANATION OF THE EQUIPMENT'S FUNCTION: (to include identifying information such as brochures and pictures)

$** **$
Purchase Price **Rental Price**