Bureau for Medical Services
Certificate of Medical Necessity
Durable Medical Equipment/Medical Supplies

SECTION I

MEMBER DATA	**SERVICING PROVIDER**	**CMN Status**
Medicaid ID#_____	Provider ID#_____	
Name_____	Provider Name_____	____Initial
D.O.B._____	Contact Person_____	____Revised
Phone # (___) _____	Phone # (___) _____	____Renewed

Section II MEMBER INFORMATION

Answer all questions that are applicable to **DME/ Medical Supplies** services being requested. If answer is **Yes**. You must describe/ attach additional information to support medical justification..

DOES PATIENT:	**YES**	**NO**
1. Have impaired mobility?	☐	☐
2. Have impaired endurance?	☐	☐
3. Have restricted activity?	☐	☐
4. Have skin break down? (Attach description of site, size, depth, and drainage)	☐	☐
5. Have impaired respiration? (Results of recent PO2/ saturation levels must be on file)	☐	☐
6. Require assistance with ADL'S ?	☐	☐
7. Have impaired speech?	☐	☐
8. Is item suitable for use in home and does the member/caregiver demonstrate willingness and ability to use the equipment?	☐	☐

9. Height: _____ Weight: _____

DATE PATIENT LAST EXAMINED BY PRACTITIONER: ____/_____/_____

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

SECTION III

Begin Service Date	**HCPCS Code**	**Item Description**	**Estimated Length of Need (# Months)**	**Quantity and Frequency Of Use**	**Dollar Amount**

SECTION IV PRACTITIONER CERTIFICATION OF MEDICAL NECESSITY

I certify that this patient meets the program eligibility criteria and that this equipment is a part of my course of treatment and is "Reasonable, Medically Necessary, and is most cost effective", and is not a convenience item for the member, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate. (Must be completed, signed and dated by the Practitioner.)

Prescribing Practitioner's Name	**Practitioner's Signature**	**Date**	**ID #**	**Phone #**

WVDHHR/BMS/CMU/CMN/Revised 04/2005