SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits):** _____

(2) DOB: ___/___/_____ **Sex:** ___ **HT:** _____ **(in) WT:** _____ **Date of Service:** _____/_____/_____

(3) Provider's name: _____ **Provider's DME #:** _____**NPI #:**_____

(4) Street address: _____ **City:** _____ **State:** ____ **Zip:** _____**Local telephone #:** _____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:

_____

_____

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD) _____ **Description(s):**_____

_____ _____

_____ _____

(8) Indicate patient's ambulatory status while performing activities of daily living: ☐ **Non-ambulatory** ☐ **Ambulatory, without assistance**

☐ **Ambulatory with the aid of a walker or cane,** ☐ **Ambulatory, with other assistance as described**

_____

_____

Does the patient have decubitus ulcers? ☐ **Yes** ☐ **No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s):** _____

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

_____

_____

_____

(9) For supplies, please indicate the dressing change required per day, week, month, etc.

_____

_____

Is additional information attached on separate sheet? _____**Yes** _____**No (If "yes," enter recipient's name & I.D. Medicaid number on attachment**

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(11) Please indicate the prescription date: _____

(12) Duration of need (maximum of 12 months): _____
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN'S NAME:_____ PHYSICIAN'S NPI #:_____

PHYSICIAN'S SIGNATURE _____DATE___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.