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

SECTION I **INDIVIDUAL DATA** **SERVICING PROVIDER**

I.D. #		**I.D. #**	010066794
Name		**Name**	TOBII DYNAVOX
D.O.B.		**Contact Person**	Malora Smith
Phone #		**Phone #**	412-209-6545

Note: The CMN can now be used to meet the Face-to-Face requirements for applicable codes.

SECTION II **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)

SEE EVAL

FACE-TO-FACE COMPLETED YES☒ NO☐ N/A ☐

NAME/TITLE/ AND DATE OF PRACTITIONER WHO COMPLETED FACE-TO-FACE

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 _____

ICD Code	Clinical Diagnoses	Date of Onset: Less than 6 months	Date of Onset: Greater than 6 months
E83.00	DISORDER OF COPPER METABOLISM	☐	☒
R47.89	OTHER SPEECH DISTURBENCES	☐	☒
		☐	☐
		☐	☐

SECTION III **(ADDITIONAL SPACE ON REVERSE)**

Begin Service Date	HCPCS Code	Item Ordered Description*	Length of Time Needed	Quantity Ordered/ x1 Month*	Frequency of Use* Justification/Comments/ Calories Per Day
UPON	E2510	TOBII DYNAVOX I-15 SGD	LIFETIME	1	DAILY
APPROVAL	E2599	GAZE INTERACTION	LIFETIME	1	DAILY
	E2512	MOUNT	LIFETIME	1	DAILY

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.

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

INDIVIDUAL NAME		**VMAP #**	
SERVICING PROVIDER NAME		**PROVIDER ID#**	

DESCRIPTION/ADDITIONAL INFORMATION

SECTION II (continued)

*For Nutritional Supplements assessor must document formula tolerance and tube/stoma site assessment if applicable. This can be documented on the CMN or in the supporting documentation, signed and dated by the practitioner. ***Complete diet order must be indicated in Section III

SECTION III (continued)

Begin Service Date	HCPCS Code	*Item Ordered Description	Length of Time Needed	*Quantity Ordered/ x1 Month	Frequency of Use* Justification/Comments/ Caloric Order Per Day

SECTION IV PRACTITIONER CERTIFICATION (MUST BE SIGNED AND DATED BY PRACTITIONER)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PRACTITIONER'S NAME (print)	PRACTITIONER'S SIGNATURE	DATE	I.D.#	PHONE #

Section I INDIVIDUAL DATA

- Complete 12-digit individual identification number
- Complete recipient full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone # (include area code)

SERVICING PROVIDER

- Complete provider number (10-digits)
- Complete provider name
- Complete contact identifying person to call if DMAS has questions

Section II INDIVIDUAL INFORMATION

- Check **ALL** boxes that apply
- Identify functional limitations related to individual and need for DME service
- If requesting oxygen, the results of PO_2/Saturation levels must be identified
- Date last examined by practitioner
- ICD Code (optional)
- Clinical diagnoses - narrative must be identified. Diagnosis must be related to the item being requested
- Check appropriate line for date of on-set

Section III

- Begin service date (month, day and year)
- Item ordered description: must be narrative description of item ordered (DME vendor may identify by HCPC Code)
- Length of Time Needed: length of time item will be needed for all durable equipment
- Quantity ordered: identify quantity ordered; for expendable supplies, designate supplies needed for 1 month; if items are required greater than 1 month, note time frame in the Length of Time Needed column (if more than one item is needed but not needed every month then the provider should indicate the appropriate amount (i.e., 1 per 2 month or 1/2M etc.)
- Frequency of Use, Justification/Comments: physician's order for frequency of use must be identified

Section IV PRACTITIONER CERTIFICATION

- Physician full name (print)
- *Must* be signed and fully dated by practitioner (**NOTE:** Attached physician prescription will ***not*** be accepted in lieu of practitioner signature/date on this form); **IF ORDERS FOR DME SERVICE ARE WRITTEN ON BOTH SIDES OF FORM, PHYSICIAN *MUST* SIGN/DATE *BOTH* SIDES OF FORM**
- Complete practitioner Medicaid provider number (optional)
- Telephone number (include area code)