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

**SECTION I** **RECIPIENT DATA** **SERVICING PROVIDER**

| | | | |
|---|---|---|---|
| **I.D. #** | | **I.D. #** | |
| **Name** | | **Name** | |
| **D.O.B.** | | **Contact Person** | |
| **Phone #** | ( ) | **Phone #** | ( ) |

**Note**: The CMN can now be used in place of DMAS-115. The original requirements for justification still apply. Additional questions have been added to the CMN (pg 1-2).

**SECTION II** **RECIPIENT INFORMATION**

Answer all questions that are applicable to DME service being requested.
If answer is yes, you must describe/attach additional information.

**DESCRIPTION/ADDITIONAL INFORMATION:**
(Additional space on reverse)

| 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 _____ | ❑ | ❑ |

**IS THE ITEM SUITABLE FOR USE IN HOME, AND DOES THE PATIENT/CAREGIVER DEMONSTRATE WILLINGNESS/ABILITY TO USE THE EQUIPMENT? YES____NO____**

**Date patient last examined by practitioner** _____

| ICD9 Code | Clinical Diagnoses | Date of Onset: Less than 6 months | Date of Onset: Greater than 6 months |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**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 PRACTIONER'S NAME (print) | PRACTITIONER'S SIGNATURE* | DATE* | I.D.# | ( ) PHONE # |
|---|---|---|---|---|
| | | | | |

*Required fields. If any of these fields are blank the CMN is not valid. **Practitioner will be a physician, physician assistant, and a nurse practitioner.
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.

***Complete diet order must be indicated in Section III

| | | | |
|---|---|---|---|
| **RECIPIENT 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 RECIPIENT DATA

- Complete 12-digit recipient 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 (7-digits)
- Complete provider name
- Complete contact identifying person to call if DMAS has questions

### Section II RECIPIENT INFORMATION

- Check **ALL** boxes that apply
- Identify functional limitations related to recipient and need for DME service
- If requesting oxygen, the results of $PO_2$/Saturation levels must be identified
- Date last examined by practitioner
- ICD9 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: practitioner's order for frequency of use must be identified

### Section IV PRACTITIONER CERTIFICATION

- Practitioner full name (print)
- *Must* be signed and fully dated by practitioner (**NOTE:** Attached practitioner 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, PRACTITIONER *MUST* SIGN/DATE *BOTH* SIDES OF FORM**
- Complete practitioner Medicaid provider number (optional)
- Telephone number (include area code)