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):** _____

Secondary Insurance_____ **Secondary Insurance ID #** _____

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

(3) **Provider's name:** Medical Select, Inc. dba Neb Doctors of SC **Provider's DME #** _____**NPI#** 1336197482

(4) **Street address:** 101 Westpark Blvd Ste A-2 **City:** Columbia **State:** SC **Zip:** 29210 **Local telephone #:** 803-772-4445

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

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

☐ **Neb Kit contains: Compressor with Nebulizer (E0570), Reusable Neb Cup (A7005) and Aerosol Mask (A7015)**

☐ **Chamber and Mask: Chamber (A4627) and Mask (A7015)**

☐ **Chamber (A4627)** ☐ **Peak Flow Meter (A4614)** ☐ **Phototherapy (E0202)**

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** N/A

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

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.** N/A

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.

I certify that I was provided clear instructions related to the use and I have received ____ Nebulizer Kit with Serial Number_____ that includes compressor with nebulizer (E0570), re-usable neb cup (A7005), and aerosol mask (A7015) OR I have received ____ Chamber/Spacer (A4627) w/mask (A7015), or ____ Chamber (A4627), or ____ Peakflow Meter (A4614), or ____ Phototherapy (E0202)

Patient/Guardian Signature Upon Delivery_____ Date: _____

PLEASE FAX COMPLETED FORM TO 888-972-9670

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**These fields are used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**