

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
PNEUMATIC COMPRESSION DEVICES AND ACCESSORIES

SECTION A: Consumer/Provider Information

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|--|---|--|--------------------|
| Certification Type: <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Recertification | | | |
| Consumer's Name | | Provider's Name | |
| Consumer DOB | Consumer Sex <input type="checkbox"/> Female <input type="checkbox"/> Male | Consumer HT (in.) | Consumer WT (lbs.) |
| (If consumer is not residing at home address) Facility Name | | Prescriber's Name | |
| | | Prescriber's NPI Number | |
| Facility Address | | Prescriber's Telephone | |
| Facility City, State and Zip Code | | Prescriber's Medicaid Legacy Number (Optional) | |

SECTION B: Information below may not be completed by the provider of the Items/Supplies

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|--|--|-------------------------|
| Est. Length of Need (# of Months) 1-99 (99= LIFETIME) | | Diagnosis Codes (ICD-9) |
| Last Consumer Medical Examination (MM/DD/YR) | | |
| ANSWERS | ANSWER QUESTIONS 1-5 FOR PNEUMATIC COMPRESSION DEVICES (Check Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted, please provide additional information on any Y responses in section (C) (2) of this form) | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D | 1. Does the consumer have chronic venous insufficiency with venous stasis ulcers? | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D | 2. If the consumer has venous stasis ulcers, have you seen the consumer regularly over the past six months and treated the ulcers with a compression bandage system or compression garment? | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D | 3. Has the consumer had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity? | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D | 4. Does the consumer have a malignant tumor with obstruction of the lymphatic drainage of an extremity? | |
| <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D | 5. Has the consumer had lymphedema since childhood or adolescence? | |
| NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (<i>Please Print</i>) | | |
| Name | Title | Employer |

SECTION C: Narrative Description of Equipment, Cost and Medical Necessity

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| (1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for <u>each</u> item, accessory, and option. |
| (2) Narrative description of all Y answers reflected in section B of this document and any additional clinical information necessary to support medical necessity of equipment and accessories being prescribed. |
| I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE) |
| Prescriber's Signature |
| Date |
| Provider's NPI Number |