

Ohio Department of Medicaid
Certificate of Medical Necessity/Prescription
Osteogenesis Bone Stimulators

SECTION A: Consumer/Provider Information

Certification Type: <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Recertification			
Consumer 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:	

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

Est. Length of Need (# of Months): 1-99 (99=LIFETIME)	Diagnosis Codes (ICD-9) and Descriptions: Pacemaker: <input type="checkbox"/> Y <input type="checkbox"/> N
Last Consumer Medical Examination (MM/DD/YR):	
NON-SPINAL STIMULATORS	
Non-union of long bone fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, joint/s affected and date of surgery: A): _____ Date: _____ B): _____ Date: _____ C): _____ Date: _____	
Note: Date of fracture must be a minimum of 3 months prior to initiating treatment.	
Failed joint/s fusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, joint/s affected and date of surgery: A): _____ Date: _____ B): _____ Date: _____ C): _____ Date: _____	
Note: Date of fracture must be a minimum of 3 months prior to initiating treatment.	
Congenital Pseudarthrosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, explain in detail:	
SPINAL STIMULATORS	
Failed spinal fusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of surgery: and level of fusion:	
Multilevel (3 or more vertebrae) spinal fusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of surgery: and level of fusion:	
Spinal fusion with history of previously failed spinal fusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of current surgery: _____ Level of fusion: _____ Date of failed spinal fusion:	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):	
NAME:	TITLE: EMPLOYER:

SECTION C: PRESCRIBER ATTESTATION

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 my 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: