DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB) for Clearance

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services (HHS), has submitted to OMB the following information collection requirement for emergency review. We are requesting an emergency review because the collection of this information is needed prior to the expiration of the normal time limits under OMB's regulations at 5 CFR, Part 1320, in order to analyze and pay claims submitted by certain medical suppliers, and is essential to the mission of HCFA. The Agency cannot reasonably comply

with the normal clearance procedures because public harm is likely to result if normal clearance procedures are followed. Without this information, HCFA could not authorize payment for only those services that are reasonable and necessary (Sections 1834 and 1861 of the Social Security Act).

HCFA is requesting that OMB provide a two-day review and a 90-day approval. During this 90-day period HCFA will publish a separate Federal Register notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. Then HCFA will submit the requirements for OMB review and an extension of this emergency approval.

1. Type of Information Collection Request: Emergency; Title of Information Collection: Durable Medical Equipment Regional Carrier, Certificate of Medical Necessity, Version I and Version II. (Either version may be used through April 1, 1996); Form No.: HCFA–R–182; Use: This information is needed to correctly process claims and insure that claims are properly paid.

These forms contain medical information necessary to make an appropriate determination.

Frequency: On occasion; Affected Public: Suppliers and Physicians, Business or other for-profit, Federal Government; Number of Respondents: 140,000; Total Annual Responses: 6.8 million; Total Annual Hours Requested: 1.7 million.

To request copies of the proposed paperwork collection referenced above, call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections should be sent within 2 working days of this notice directly to the OMB Desk Officer designated at the following address: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: October 3, 1995. Kathleen B. Larson, Director, Management Planning and Analysis Staff.

BILLING CODE 4120-03-P

Effectiv		MENT REGIONAL CARRIER DMERC 10.01				
CERTIFICATE OF MEDICAL NECESSITY: PARENTERAL OR ENTERAL NUTRITION						
SECTION	A INITIAL INEVISED INTERPRETATION					
PATIENT	NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER				
Į.) - HICN	() NSC				
PLACE O	OF SERVICE REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE				
NAME A	ND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM)					
SECTION	L R CLINICAL IN	FORMATION				
	SIS (ICD9):	PT. HT (IN.) PT. WT (LBS) DOB//				
	EXAMINED THIS PATIENT FOR THIS	DATE NEEDED INIT / / REV/RECERT/				
	ION ON:// PT. SEX (M OR F)	EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)				
ANSWE	R QUESTIONS 1-6 FOR PARENTERAL, ANSWER 2, 6-15 FOR ENTE	ERAL Use Y - Yes, N - No or D for Does Not Apply unless otherwise				
noted.	-					
[]1.	Does the patient have severe permanent disease of the	[] 8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with				
	gastrointestinal tract which prevents absorption of sufficient nutrients to maintain weight and strength commensurate with the					
	patient's overall health status?					
[] 2 .	Do the number of calories prescribed average 20-35 cal/kg/day?	[] 9. What is the prescribed route of administration? 4 - Nesogastric tube				
	So the hallow or survive processes are as a survive processes.	5 - Gastrostomy tube				
[] 3.	Days per week infused? Enter 1-7.	6 - Jejunostomy tube				
4.	Formula components:	10. Product name?				
	the testing and the second sec	11. Calories per day?				
	cid(ml/day) concen % gms protein/day					
Dextros	e (ml/day) concen %	[] 12. Days per week administered? Enter 1-7.				
1 inide	ml/day days/week concen %	[] 13. Mernod of administration?				
		1 - Syringe				
[] 5.	What is the route of administration? 1 - Central line	2 - Gravity 3 - Pump				
	2 - Peripheral line	·				
	3 - Hemodialysis access line	[] 14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?				
	7 - Peripherally inserted central catheter (PICC)	semi-synthetic nutrients:				
[]6.	Has there been a break in therapy of two or more consecutive	15. Additional information when required by policy:				
	months, necessitating a new certification, during which time the					
	patient did not receive enteral or parenteral feeding?					
[]7.	Does the patient have permanent nonfunction or disease of the					
	structures that normally permit food to reach the small bowel?					
1	the medical reseasing of these items for this nation! Section B of	this form and any statement on my letterhead attached hereto has been				
complet	ted by me or reviewed by me. The foregoing information is true, a	ccurate, and complete, and I understand that any falsification, omission, or				
conceal	ment of material fact may subject me to civil or criminal liability.	_				
PHYSIC	IAN NAME, ADDRESS	I = I				
		PHYSICIAN'S SIGNAT - DATE				
	· · · · · · · · · · · · · · · · · · ·	(A STAMPED SIGNATURE IS NOT ACCEPTABLE)				
		☐ Attending ☐ Consulting ☐ Other ordering				
		UPIN:				
1						

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification, revised certification,

or recertification. Refer to your supplier manual for more information.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

SECTION B: (To be completed or reviewed and signed by the ordering physician)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the beginning of this certification period.

PT. HT., PT. WT., DOB:

Indicate the patient's height in inches and weight in pounds. Indicate patient's date of birth

(MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category for the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: -

Department of Health and Human Services Health Care Financing Administration		Form Approved OMB No. 0938-0534
ATTENDING PHYSICIAN HOME OXYGEN TH	IERAPY (Legible han	OF MEDICAL NECESSITY FOR nowritten entries acceptable)
notic reporting burden for this collection of information is estimated to average 15 minutes to data needed, and completing and reviewing the collection of information. Send comme is burden, to HCFA, P.O. Box 2004, Seltimore, MD 21207; and to the Office of Informati	per response, including the time rits regarding this burden setting on and Regulatory Atlairs, Office	ne for reviewing instructions, searching existing data sources, gathering and maintaining sale or any other expect of this collection of information, including suggestions for reducing so of Management and Budget, Washington, DC 20503.
Patient's Name, Address, and HIC No.	Supplie	er's Name, Address, and Identification No.
	·	
·		
Certification:	Initial Revis	ised Renewed
INFORMATION BELOW TO BE ENT	ERED ONLY BY PHY	YSICIAN OR PHYSICIAN'S EMPLOYEE
Pertinent Diagnoses, ICD-9-CM Codes, and Findings - C	HECK ALL THAT AP	PPLY: 2.A. I last examined this patient for this
Emphysema (492.8) Chronic Obs	tructive Bronchitis (49	91.2) condition on:
COPD (496) Chronic Obs	tructive Asthma (493.	(.20) Month Day Year
☐ Cor Pulmonale (416.9) ☐ Congestive I	leart Failure (428.0)	2.B. Home oxygen prescribed:
	Polycythernia (289.0)	I MODIN DAV 1941
	57% or more Yes	No 2.C. Estimated length of need:
Specify Code		1-3 months 4-12 months Lifetime
A. Results of Most Recent Arterial Blood Gas and/or Oxy	gen Saturation Tests	(Patient Breathing Room Air) sician/Provider Performing Test(s) (Printed/Typed Name
PO2 02 Saturation Date		Address):
(1) At Rest		
(2) Sleeping		
(3) Exercising		
(4) Other: B. If performed under conditions other than room air, expl.	ain	
A. Supply System (1) Stationary	a particular form of de	Exercise ProgramOther (specify)
. If you have prescribed a portable or ambulatory system, in the home and which cannot be met by a stationary sy	describe activities/ex ystem (e.g., amount a	cercise that patient regularly pursues which require this syst and frequency of ambulation).
	CERTIFICATION	
IS PRESCRIBED (*) MEDICALLY INDICATED AND IS REASONA INY STATEMENT ON MY LETTERHEAD ATTACHED HERETO H COREGOING INFORMATION IS TRUE, ACCURATE, AND COMPL CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CI	BLE AND NECESSARY AS BEEN COMPLETED LETE, AND I UNDERSTA ALL OR CRIMINAL LIAB	D BY ME, OR BY MY EMPLOYEE AND REVIEWED BY ME. THE CAND THAT ANY FALSIFICATION, OMISSION, OR BILITY.
Attending Physician's Signature: (A STAMPED SIGNATUR	E IS NUT AUGEPTA	DAIG.
Physician's Name, Address, Telephone No., and Identificat	ion No.:	
orm HCFA-484 (5-90)		◆U.S.GPO (BMC)

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 09.01 Effective 10/93 CERTIFICATE OF MEDICAL NECESSITY: INFUSION PUMPS/HOME GLUCOSE MONITORS SECTION A CERTIFICATION: ☐ INITIAL ☐ REVISED SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO. NSC HICN HCPCS CODE(S) WARRANTY LENGTH TYPE PLACE OF SERVICE REPLACEMENT ITEM NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM): INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE SECTION B (LBS) DOB DIAGNOSIS (ICDS): PT, HT. (IN.) PT. WT. REVISED I LAST EXAMINED THIS PATIENT FOR THIS DATE NEEDED INITIAL 1-99 (99 = LIFETIME) CONDITION ON: PT. SEX (M OR F) EST. LENGTH OF NEED: # OF MONTHS: ANSWER QUESTIONS 1-8 FOR INFUSION PUMPS, ANSWER 9-13 FOR HOME GLUCOSE MONITORS Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted. [] 7. Does the patient have intractable cancer pain which has failed INFUSION PUMP to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal 1. Which pump has been prescribed? 1 -Ambulatory infusion pump narcotics? Stationary infusion pump 2 -[] 8. Is the patient a cardiac transplant candidate on active status? 3 -Implantable infusion pump Disposable infusion pump (e.g., elastomeric) HOME GLUCOSE MONITOR 2. Provide the HCPCS code for the drug that requires the use of the [] 9. Does the patient have insulin-treated diabetes? pump. [] 10. Does the patient have documented episodes of - widely fluctuating blood sugars, and/or - recurring insulin reactions, and/or 3. If a non-specific code was used to answer question 2, provide the - kntoacidosis? name of the drug. [] 11. Is the patient or caregiver capable of learning proper operation of the device? What is the route of administration? [] 12. Is the device designed for home rather than clinic use? 1 intravenous. 2 -Intra-arterial 13. Approximately how many times per week is the patient 3 -**Epidural** expected to check his/her blood sugar? Enter the number of 4 -Subcutaneous times per week 01 - 99. 5. What is the method of administration? 1 -Continuous Intermittent 2 -Bolus 3 -6. What is the total duration of drug infusion per 24 hours? (Enter number of hours 1 - 24). I certify the medical necessity of these items for this patient. Section 8 of this form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may aubject me to civil or criminal liability. NIVO 101441 414445 4000500

HTSICIAN NAME, AUDRESS	
	PHYSICIAN'S SIGNATURE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE)
•	☐ Attending ☐ Consulting ☐ Other ordering
	UPIN:
	TELEPHONE #: ()

08,16/93

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

SECTION 8: (To be completed by the physician or physician's employee)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the beginning of this certification period.

PT. HT., PT. WT., DOB:

Indicate the patient's height in inches and weight in pounds (for infusion pumps). Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

			AL EQUIPMENT REGIONAL CARRIER DMERC 08.01
·		CERTIFICATE OF MEDIC	AL NECESSITY IMMUNOSUPPRESSIVE DRUGS
SECTIO	NA CERTIFI	CATION: INITIAL REVISED	
PATIEN	T NAME, ADDRES	SS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER
ı) -	HICN	() NSC
PLACE	OF SERVICE	REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE
NAME A	AND ADDRESS OF	F FACILITY IF APPLICABLE (SEE BACI	(OF FORM):
SECTION	N B	C	LINICAL INFORMATION
DIAGNO	OSIS (ICD9):		PT. HT (IN.) PT. WT (LBS) DOB //
	EXAMINED THIS TON ON:/	PATIENT FOR THIS	OR F) DATE NEEDED INITIAL / REVISED / / EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)
ANSWE		ug(s) prescribed and the dosage and f	S Use Y · Yes, N - No or D for Does Not Apply unless otherwise noted. 7. Transplant procedure code (CPT code).
	HCPCS	MG TIMES PER DAY	8. Name of facility where transplant was performed.
	2		9. City where facility is located.
	3		
[] 4.	Has the patient Medicare?	had an organ transplant that was cov	ered by10. State where facility is located.
5. 	transplant)	gans have been transplanted? (Most i	recent 11. On what date was the patient discharged from the hospital following this transplant surgery?
_	1 - 2 -	Heart Liver	
	3 -	Kidney	
	4 -	Bone Marrow	[] 12. Was there a prior transplant failure of this same organ?
	5 - May enter up to	Lung three different organs.	
6.	On what date v	vas the transplant surgery performed,	requiring this
		<u> </u>	•
complet	ted by me, or revi	seity of these items for this patient. weed by me. The foregoing informati al fact may subject me to civil or crim	Section 8 of this form and any statement on my letterhead attached hereto has been on is true, accurate, and complete, and I understand that any falsification, omission, inal liability.
PHYSIC	IAN NAME, ADD	RESS	
			PHYSICIAN'S SIGNATURE: (A STAMPED SIGNATURE IS NOT ACCEPTABLE)
			☐ Attending ☐ Consulting ☐ Other ordering
			UPIN:
i			TELEPHONE #: ()

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

60.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility

(SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

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SECTION 8: (To be completed or reviewed and signed by the ordering physician)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

PT. HT., PT. WT., DOB:

Indicate the patient's height in inches and weight in pounds. Indicate patient's date of birth

(MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/93 DURABLE MEDICAL EQUIPM	IENT REGIONAL CARRIER DMERC 07.01				
CERTIFICATE OF MEDICAL NECESSITY: SEAT LIFT MECHANISMS/POWER OPERATED VEHICLES (POV)					
SECTION A CERTIFICATION: INITIAL REVISED					
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER				
() HICN	() NSC				
PLACE OF SERVICE REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE				
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):					
	W THE DUVING A HOD DUVING AN'S EMBLOYEE				
SECTION 8 INFORMATION BELOW TO BE COMPLÉTED ONLY B	DOB / /				
DIAGNOSIS (ICD9):					
LAST EXAMINED THIS PATIENT FOR THIS CONDITION ON:/ PT. SEX (M OR F)	DATE NEEDED INITIAL / REVISED / EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)				
ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISMS, ANSWER QUES	TIONS 6-14 FOR POWER OPERATED VEHICLES (POV)				
Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.	[] 9. Is the patient capable of safely transferring in and out of the				
SEAT LIFT MECHANISM 1. Does the patient have severe arthritis of the hip or knee?	POV?				
[] 2. Does the patient have a severe neuromuscular disease?	[] 10. Is the patient capable of safely operating the controls of the POV?				
[] 3. Is the patient completely incapable of standing up from a regular armchair or <u>any</u> chair in his/her home?	[] 11. Does the patient have adequate trunk stability to be able to safely ride in the POV?				
[] 4. Once standing, does the patient have the ability to ambulate?	[] 12. Are you a specialist in physical medicine, orthopedic surgery,				
[] 5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's records.	neurology, or rheumatology? I [] 13. Is the patient more than one day's roundtrip from a specialist in physical medicine, orthopedic surgery, neurology, or				
,	reumatology?				
POWER OPERATED VEHICLE	[] 14. Does the patient's condition preclude a visit to a specialist in				
[] 6. Would the patient be bed or chair confined without the use of a wheelchair?	physical medicine, orthopedic surgery, neurology, or rheumatology?				
[] 7. Is the patient unable to operate a manual wheelchair?	·				
[] 8. Can the patient ambulate in the home but the POV is required for movement outside the home?	· · · · · · · · · · · · · · · · · · ·				
I certify the medical necessity of these items for this patient. Section B of completed by me, or by my employee and reviewed by me. The foregoing feleification, omission, or concealment of material fact may subject me to c	information is true, accurate, and complete, and I understand that any				
PHYSICIAN NAME, ADDRESS] ·				
	PHYSICIAN'S SIGNATURE: (A STAMPED SIGNATURE IS NOT ACCEPTABLE)				
	☐ Attending ☐ ☐ sulting ☐ Other ordering				
	UPIN:				
·	l				

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

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PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility

(SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

HCPCS CODES:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of

warranty must be indicated.

SECTION B: (To be completed by the physician or physician's employee)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

DOB:

Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION: .

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/93 DURABLE MEDICAL EQUIPN	
CERTIFICATE OF MEDIC	AL NECESSITY: TENS
SECTION A CERTIFICATION: INITIAL REVISED	
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER
	and the state of t
() HICN	() NSC
PLACE OF SERVICE REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):	
NAME AND ADDRESS OF FACILITY IF AFFEICABLE (SEE BACK OF TORING)	
•	
	<u> </u>
SECTION B INFORMATION BELOW TO BE COMPLETED ONLY	BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE
DIAGNOSIS (ICD9):	DO8 / /
I LAST EXAMINED THIS PATIENT FOR THIS	DATE NEEDED INITIAL/ REVISED/
CONDITION ON:/ PT. SEX (M OR F)	EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)
ANSWER QUESTIONS 1-8 FOR RENTAL OF TENS, AND 3-12 FOR PURCHA	ASE OF TENS Use Y - Yes, N - No or D for Does Not Apply unless
otherwise noted.	What are the dates that trial of TENS unit began and ended?
[] 1. Does the patient have acute post-operative pain?	
	/
What is the date of the surgery resulting in acute post-operative pain?	
	9. What is the date that you reevaluated the patient at the end
	of the trial period?
[] 3. Does the patient have chronic, intractable pain?	
	10. How often has the patient been using the TENS?
4. How long has the patient had intractable pain?	1 = Daily
Enter number of months 1-99.	2 = 3 to 6 days per week
	3 = 2 or less days per week
5. For which, if eny, of the following conditions is the TENS unit	
being prescribed?	[] 11. Do you and the patient agree that there has been a significant improvement in the pain and that long term use of a TENS is
1 - Headache 2 - Visceral abdominal pain	warranted?
3 - Pelvic pain	
4 - Temporomandibular joint (TMJ) pain 5 - None of the above	12. Number of TENS leads (i.e., separate electrodes) routinely
3 110 12 110 12 110 12 12 12 12 12 12 12 12 12 12 12 12 12	needed and used by the patient at any one time:
[] 6. Is there documentation in the medical record of multiple medica-	2 = 2 Leads 4 = 4 Leads
tions and/or other therapies that have been tried and failed?	
	•
[] 7. Has the patient received a TENS trial?	
I certify the medical necessity of these items for this patient. Section B of	this form and any statement on my letterhead attached hereto has been
completed by me, or by my employee and reviewed by me. The foregoing falsification, omission, or concealment of material fact may subject me to	information is true, accurate, and complete, and i understand that only civil or criminal liability.
PHYSICIAN NAME. ADDRESS	7
PHYSICIAN NAME, ADDRESS	0.75
	PHYSICIAN'S SIGNATURE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE)
	☐ Attending ☐ Consulting ☐ Other ordering
	UPIN:
	TELEPHONE #: ()
I .	

CERTIFICATION TYPE: Check the appropriate box to indicate if this C

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION: Indicate the beneficiary's name, permanent legal address, telephone number and his/her health

insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility

(SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT: If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the

Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require

a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of

warranty must be indicated.

SECTION B: {To be completed by the physician or physician's employee}

DIAGNOSIS: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List

any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE: Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

DOB: Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED: Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting.

If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to

require use of the ordered item) by filling in the appropriate number of months. If the physician

expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each

question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does

not apply, unless otherwise noted.

PHYSICIAN INFORMATION: The physician's signature certifies that the item ordered is medically necessary for this patient and

that section B was completed or reviewed by the physician. This form must be signed and dated

by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician

by putting a check mark in the appropriate box. Indicate other ordering when you are neither the

attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS: Indicate physician's name and complete mailing address.

UPIN: The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: The physician must give a telephone number where he/she can be contacted (preferably a number

where records would be accessible pertaining to this patient) if more information is needed.

	L EQUIPMENT REGIONAL CARRIER DMERC 05.01
	SITY: SURGICAL DRESSINGS / UROLOGICAL SUPPLIES
SECTION A CERTIFICATION: INITIAL	Tourney on Market Anness and Spilone and Alexander
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER
, wen	()NSC
PLACE OF SERVICE REPLACEMENT ITEM	HCPCS CODE(S)
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK	OF FORM):
SECTION B CI	LINICAL INFORMATION
DIAGNOSIS (ICD9):	DOB//
LAST EXAMINED THIS PATIENT FOR THIS	DATE NEEDED INITIAL/ REVISED//
CONDITION ON:/ PT. SEX (M O	
ANSWER QUESTIONS 1-3 AND 5-7 FOR SURGICAL DRESSING Use Y - Yes, N - No or D for Does Not Apply unless otherwise	
SURGICAL DRESSINGS	
1. Does the patient have a surgical wound?	
2. Number of surgical wounds (enter number).	
3. Date of surgical procedure: (MM/DD/YY)/	<u></u>
UROLOGICAL SUPPLIES	•
[] 4. Does the patient have permanent urinary incontinen	ce?
1 4. Does the parallel have pulliment arrively mountainer	
5. <u>Dressings/Urological Supplies Ordered</u>	6. HCPCS Code 7. Frequency of Change
certify the medical necessity of these items for this patient. S	section 8 of this form and any statement on my letterhead attached hereto has been
completed by me or reviewed by me. The foregoing information	n is true, accurate, and complete, and I understand that any falsification, omission.
or concealment of material fact may subject me to civil or crimi	nal liability.
PHYSICIAN NAME, ADDRESS	
	PHYSICIAN'S SIGNATURE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE)
	TA STAINTED SIGNATURE IS NOT AGGET TAGES
	☐ Attending ☐ Consulting ☐ Other ordering
	UPIN:
	TELEPHONE # . (

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

SECTION 8: (To be completed or reviewed and signed by the ordering physician)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

DOB:

Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

The physician must give a telephone number where he/she can be contacted (preferably a number where records would be accessible pertaining to this patient) if more information is needed.

DRESSINGS/SUPPLIES ORDERED:

Describe the type of dressing or urological supplies ordered (use of a brand name optional).

HCPCS COD

In the spaces provided, indicate the appropriate HCPCS code(s) for the item(s) ordered.

FREQUENCY OF CHANGE:

In the space provided, indicate frequency of change for each item ordered. (Refer to medical

policy.)

Effective 10/93 DURABLE MEDICAL EQUIPM				
CERTIFICATE OF MEDICAL NECESSITY: ORTHOTICS/LYMPHEDEMA PUMPS/OSTEOGENESIS STIMULATORS/THERAPEUTIC SHOES				
SECTION A CERTIFICATION: INITIAL REVISED				
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER			
() HICN	() Nsc			
PLACE OF SERVICE REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE			
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM)				
	HE PHYSICIAN OR PHYSICIAN'S EMPLOYEE (EXCEPT QUESTIONS 1-6)			
DIAGNOSIS (ICD9):	DOB//			
I LAST EXAMINED THIS PATIENT FOR THIS CONDITION ON:/ PT. SEX (M OR F)	EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)			
ANSWER QUESTIONS 1-6 FOR ANKLE-FOOT AND KNEE-ANKLE-FOOT OR STIMULATORS, 16 FOR THERAPEUTIC SHOES. Use Y - Yes, N - No, or E	THOTICS, 7-11 FOR LYMPHEDEMA PUMPS, 12-15 FOR OSTEOGENESIS of Does Not Apply unless otherwise noted.			
ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOTICS	[] 10. Is there postinflammatory lymphatic obstruction?			
[] 1. Does the patient have weakness or deformity of the foot and ankle which requires stabilization to achieve functional benefit?	[] 11. Have suitable instructions as to the pressure to be used and the frequency and duration of use been provided?			
[] 2. Does the patient have weakness or deformity of the knee which requires stabilization to achieve functional benefit?	OSTEOGENESIS STIMULATOR [] 12. Does the patient have a nonunion of a long bone fracture?			
[] 3. Is the condition expected to exist for more than 6 months?	[] 13. Does the patient have a failed fusion?			
[] 4. Is the patient unable to be fitted with a custom-fitted orthosis?	[] 14. Does the patient have a congenital pseudarthrosis?			
[] 5. Is there a need to control the knee, ankle, or foot in more than one plane?	15. How many months ago did the patient sustain the long bone fracture being treated or have the fusion that has			
[] 6. Does the patient have a documented neurological, circulatory, or orthopedic status (e.g. a healing fracture lacking normal anatomical integrity or anthropometric proportions integrity or anthropometric proportions.	failed? (ENTER THE NUMBER OF MONTHS 1 - 99) THERAPEUTIC SHOES			
custom fabricating over a model to prevent tissue injury?	[] 16. Are you the physician who is managing the patient's systemic diabetic condition?			
[] 7. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?				
[] 8. Has the patient had surgery or radiation that interrupted normal lymphatic drainage or is there a congenital abnormality of lymphatic drainage?				
[] 9. Is the device prescribed for the treatment of chronic venous insufficiency with edema and/or venous ulcers?				
I certify the medical necessity of these items for this patient. Section B of completed by me, or by my employee and reviewed by me (except question physician review). The foregoing information is true, accurate, and complematerial fact may subject me to civil or criminal liability. PHYSICIAN NAME, ADDRESS	ins 1-6, which do not require physician completion but do require			
	PHYSICIAN'S SIGNATURE: DATE			
	PHYSICIAN'S SIGNATURE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE)			
	☐ Attending ☐ Consulting ☐ Other ordering			
	UPIN: TELEPHONE #: ()			
	08 (6.			

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank,

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

SECTION B: (To be completed by the physician or physician's employee, except for questions 1-6)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the beginning of this certification period.

Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

DOR:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted. Questions 1-6 (Ankle-Foot/Knee-Ankle-Foot Orthotics) do not require physician completion, but do require physician review.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/9	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 03.0			
CERTIFICATE OF MEDICAL NECESSITY: RESPIRATORY EQUIPMENT				
SECTION A	CERTIFICATION: INITIAL REVISED			
PATIENT NAME,	ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER		
<u></u>	· HICN	() NSC		
PLACE OF SERV	ICE REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE		
NAME AND ADD	RESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):			
SECTION B	INFORMATION BELOW TO BE COMPLETED ONLY I			
DIAGNOSIS (ICD		DOB/		
CONDITION ON:		DATE NEEDED INITIAL / / REVISED / / REVISED EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)		
ANSWER QUEST	TIONS 12-14 FOR CPAP, 18-22 FOR SUCTION PUMP. Use	Y - Yes, N - No, or D for Does Not Apply unless otherwise noted.		
1. Reserve	ed for future use.	[] 13. is surgery a likely alternative to CPAP?		
2. Reserve	ed for future use.	[] 14. Does the patient have obstructive sleep apnea?		
3. Reserve	ed for future use.	15. Reserved for future use.		
4. Recerve	ed for future use.	16. Received for future use.		
5. Reserve	ed for future use.	17. Reserved for future use.		
6. Reserve	ed for future use.	SUCTION PUMP [] 18. Does the patient have difficulty raising and clearing		
7. Reserve	ed for future use.	secretions?		
8. Reserve	ed for future use.	[] 19. Does the patient have cancer or surgery of the throat or mouth?		
9. Reserve	ed for future use.	[] 20. Does patient have dysfunction of the swallowing muscles?		
10. Reserve	ed for future use.	[] 21. Is the patient unconscious or in an obtunded state?		
11. Reserve	ed for future use.	[] 22. Does patient have a tracheostomy?		
CONTINUOUS P	OSITIVE AIRWAY PRESSURE SYSTEM (CPAP)	1 2 mm. stree passing managements.		
12.	How many episodes of apnea lasting greater than 10 seconds does the patient have during 6-7 hours of recorded sleep? (Number of episodes).	· · · · · · · · · · · · · · · · · · ·		
completed by me falsification, omi	 e by my employee and reviewed by me. The foregoing is seion, or concealment of material fact may subject me to cr 	his form and any statement on my letterhead attached hereto has been information is true, accurate, and complete, and I understand that any vill or criminal liability.		
PHYSICIAN NAR	AE, ADDRESS	_ 1 _ 1		
		PHYSICIAN'S SIGNATURE: (A STAMPED SIGNATURE IS NOT ACCEPTABLE)		
		☐ Attending ☐ Consulting ☐ Other ordering		
		UPIN:		
	7	TELEPHONE #: ()		

28 16 93

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 55, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of

warranty must be indicated.

SECTION B: (To be completed by the physician or physician's employee)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

DOB:

Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

ffective 10/93 DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 02.01				
CERTIFICATE OF MEDICAL NECESSITY: MANUAL/MOTORIZED WHEELCHAIRS				
SECTION A CERTIFICATION: [INITIAL] REVISED				
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER			
	- · · · · · · · · · · · · · · · · · · ·			
	NSC			
() HICN	HCPCS CODE(S) WARRANTY LENGTH TYPE			
PLACE OF SERVICE REPLACEMENT ITEM	HCFCS CODE(S) WARRANT! EERSTH 1772			
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):				
SECTION B INFORMATION BELOW TO BE COMPLETED ONLY	THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE			
DIAGNOSIS (ICD9):	PT. HT. (IN.) PT. WT. (LBS) DOB/			
I LAST EXAMINED THIS PATIENT FOR THIS	DATE NEEDED INITIAL / / REVISED / _ /			
CONDITION ON:/ PT. SEX (M OR F)	EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)			
ANSWER QUESTIONS 1-4 FOR MOTORIZED WHEELCHAIR BASE, 4, 18-22	FOR MANUAL WHEELCHAIR BASE, 4-18 FOR WHEELCHAIR OPTIONS.			
Use Y - Yes, N - No, or D for Does Not Apply unless otherwise noted.				
[] 1. Does the patient have severe weakness of the upper extremities due to a neurologic or muscular disease/condition?	[] 12. Does patient have weak upper body muscles, upper body insta-bility or muscle spasticity?			
[] 2. Is the patient unable to operate a wheelchair manually?	[] 13. Does patient have use of only one hand/arm and the condition is expected to last for 6 months or more?			
[] 3. Is the patient capable of <u>safely</u> operating the controls of a power wheelchair?	[] 14. Is there hemiplegia or uncontrolled arm movements?			
[] 4. Would the patient be bed or chair confined without the use of a wheelchair?	[] 15. Does patient have a need for arm height different than that available using non-adjustable arms?			
[] 5. Does patient have quadriplegia?	[] 16. Does the patient need to rest in a recumbent position two or more times during the day?			
[] 6. Does patient have a fixed hip angle?	[] 17. Is transfer between bed and wheelchair very difficult?			
[] 7. Does patient have a trunk cast or brace that requires a reclining				
back feature for positioning?	18. How many hours per day does the patient usually spend in the wheelchair? (round up to next hour, e.g., for 3 1/2 hours,			
[] 8. Does the patient have a cast or brace which prevents 90 degree	use 4) use 1-24.			
flexion of the knee?	[] 19. Is the patient able to place his/her feet on the ground for			
[] 9. Does patient have a musculoskeletal condition that prevents 90	propulsion in a standard wheelchair?			
degree flexion at the knee?	[] 20. Is the patient able to self-propel in a standard wheelchair?			
[] 10. Does patient have excessive extensor tone of the trunk muscles?				
f 144 Managara base week make menale and iting number?	[] 21. Reserved for future use.			
[] 11. Does patient have weak neck muscles requiring support?	[] 22. Can/does patient self-propel in a lightweight wheelchair?			
I certify the medical necessity of these items for this patient. Section B of completed by me, or by my employee and reviewed by me. The foregoing falsification, omission, or concealment of material fact may subject me to c	information is true, accurate, and complete, and I understand that any			
PHYSICIAN NAME, ADDRESS	7			
	PHYSICIAN'S SIGNATURE: DATE			
	(A STAMPED SIGNATURE IS NOT ACCEPTABLE)			
	☐ Attending ☐ Consulting ☐ Other ordering			
	UPIN:			
	TELEPHONE #: ()			

08.16.93

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the

Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

HCPCS CODES:

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

SECTION B: (To be completed by the physician or physician's employee)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

PT. HT., PT. WT., DOB:

Indicate the patient's height in inches and weight in pounds (when required by individual policy)

Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/93 DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DIMERC 01.01					
CERTIFICATE OF MEDICAL NECESSITY: H					
SECTION A CERTIFICATION: INITIAL REVISE					
PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.	SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER				
()HICN	() NSC				
PLACE OF SERVICE REPLACEMENT ITEM	HCPCS CODE(S) WARRANTY LENGTH TYPE				
NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):					
SECTION B INFORMATION BELOW TO BE COMPLETED ONLY BY	Y THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE				
DIAGNOSIS (ICD9):	DOB //				
LAST EXAMINED THIS PATIENT FOR THIS CONDITION ON:/ PT. SEX (M OR F)	DATE NEEDED INITIAL / / REVISED / / EST. LENGTH OF NEED: # OF MONTHS: 1-99 (99 = LIFETIME)				
ANSWER QUESTIONS 1-7 FOR HOSPITAL BEDS, 12-13 AND 21 FOR ALTERN	NATING PRESSURE PADS OR MATTRESSES, 13-22 FOR AIR-FLUIDIZED				
BEDS Use Y - Yes, N - No, or D for Does Not Apply unless otherwise noted. [] 1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?	[] 14. Does the patient have coexisting pulmonary disease?				
2. Reserved for future use.	[] 15. Has a conservative treatment program been tried without success?				
[] 3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?	[] 16. Was a comprehensive assessment performed after failure of conservative treatment?				
[] 4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?	[] 17. Is the home electric system sufficient for the anticipated increase in energy consumption?				
[] 5. Does the patient require traction which can only be attached to a hospital bed?	[] 18. Is structural support adequate to support the air-fluidized bed?				
[] 6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?	 [] 19. Are open, moist dressings used for the treatment of the patient? [] 20. Is there a trained fulltime caregiver to assist the patient and manage all aspects involved with the use of the bed? 				
Does the patient require frequent changes in body position and/or have an immediate need for a change in body position? Reserved for future use.	21. Provide the stage and size of each pressure area/ulcer necessitating the use of the overlay, mattress or bed. Pressure area/Ulcer #1 #2 #3				
Reserved for future use. 9. Reserved for future use.	Stage:				
[] 10. Reserved for future use.	Max Length (cm):				
[] 11. Reserved for future use.	22. Over the past month, the patient's ulcer(s) has/have:				
[] 12. Is the patient highly susceptible to decubitus ulcers?	1) improved 2) remained the same 3) worsened				
[] 12. Is the patient highly susceptible to decubitus ulcers? I cartify the medical necessity of these items for this patient. Section B of this completed by me, or by my employee and reviewed by me. The foregoing infi	s form and any statement on my letterhead attached hereto has been formation is true, accurate, and complete, and I understand that any				
PHYSICIAN NAME, ADDRESS					
	PHYSICIAN'S SIG. AUTRE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE)				
	☐ Attending ☐ Consulting ☐ Other ordering				
	UPIN:				
	TELEPHONE #: ()				

CERTIFICATION TYPE:

Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this

is a revised certification.

BENEFICIARY INFORMATION:

Indicate the beneficiary's name, permanent legal address, telephone number and his/her health

insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim

form.

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility

(SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for

a complete index.

REPLACEMENT:

If the item billed is a replacement for a previously purchased item, place a check mark in the blank.

FACILITY NAME:

HCPCS CODES:

If the place of service is a facility, indicate the name and complete address of the facility.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of

warranty must be indicated.

SECTION B: (To be completed by the physician or physician's employee)

DIAGNOSIS:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).

EXAMINATION DATE:

Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the

beginning of this certification period.

DOB:

Indicate patient's date of birth (MM/DD/YY).

DATE NEEDED:

indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.

PHYSICIAN INFORMATION:

The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.

The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN-

The physician must indicate his/her Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

08-93

12.7

12.7 Certificate of Medical Necessity Forms

The Certificate of Medical Necessity forms are numbered in the upper right-hand corner. These numbers are referred to in the documentation section of the policies to which the CMN applies. The last two digits of the CMN form number (after the decimal point) refer to the version number. As of this printing, the most current CMN form version numbers are ".01." Over time, these version numbers may change on the different forms, based on medical policy changes. You will be notified when new versions of the CMN forms are required.

These CMNs may be photocopied and used for submission to your Region A DMERC for processing. The instructions vary with the form. Read them carefully. On the back of each CMN are instructions about completing the form. The bank of the form need not be copied for submission.

Other questions concerning completion of these forms may be addressed to Supplier Services at 1-800-842-2563.

CMN Number	Policy	Policy Page Numbers	CMN Number	Policy	Policy Page Numbers
DMERC 01.01	Hospital Beds Support Surfaces	13-59 13-96	DMERC 07.01	Seat Lift Mechanisms Power Operated Vehicles	13-9 13-19
DMERC 02.01	Motorized Wheelchair Base Manual Wheelchair Base Wheelchair Options	13-66 13-69 13-74	DMERC 08.01	Immunosuppressive Drug	s 13-15
DMERC 03.01	Nebulizers IPPB Suction Pumps	(future use) (future use) 13-36	DMERC 09.01	Infusion Pumps Home Glucose Monitor	13-106 13-11
DMERC 04.01	Ankle/Foot Orthosis Lymphedema Pumps Ostiogenesis Stimulator Therapeutic Shoes	13-33 13-104 13-17 (future use)	DMERC 10.01	Enteral Nutrition Parenteral Nutrition	13-110 13-114
DMERC 05.01	Surgical Dressing Urological Supplies	13-97 13-54	Form 484	Home Oxygen Therapy	13-86
DMERC 06.01	TENS	13-29			

08-93

MEDICAL OVERVIEW

12.6

Power Operated Wheelchair and Wheelchair with other special features

covered if patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate the wheelchair manually. Any claim involving a power wheelchair or a wheelchair with other special features should be referred for medical consultation since payment for the special features is limited to those which are medically required because of the patient's condition.

Note: A power-operated vehicle that may appropriately be used as a wheelchair can be covered.

Whirl-A-Bath

deny-(see Portable Whirlpool Pumps)

Whirl-O-Matic

deny-(see Portable Whirlpool Pumps)

Whirlpool Bath Equipment (standard) covered if patient is homebound and has a condition for which the whirlpool bath can be expected to provide substantial therapeutic benefit justifying its cost. Where patient is not homebound but has such a condition, payment is restricted to the cost of providing the services elsewhere, e.g., an outpatient department of a participating hospital, if that alternative is less costly. In all cases, refer claim to medical staff for a determination.

Whirlpool Pumps

deny-(see Portable Whirlpool Pumps)

Effective 10/01/95

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 01.02A

	Certificate Of Medical N	lecessity: HOSPITAL BEDS	PAGE 1 OF 2		
SECTION A		NITIAL// REVISED//_			
PATIENT NAME, ADDRE	SSS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NU	MBER		
		. NSC#			
	HICN				
PLACE OF SERVICENAME and ADDRESS of FACILITY if applicable (see reverse):		1 1101 00 1101 1101	VARRANTY (see reverse) onths) Type (1-4)		
SECTION B	Information Below May Not Be Comp	leted By The Supplier Of The Items/Supplies, Nor			
	Anyone In A Financial Relationship W	Ath The Supplier.			
ST. LENGTH OF NEE	D (# OF MONTHS): 1-99 (99=LIFETIME	DIAGNOSIS CODES (ICD-9):			
ANSWERS	ANSWER QUESTIONS 1, AND 3-7 FOR H	OSPITAL BEDS for Yes, N for No, or D for Does Not Apply)			
	QUESTION 2 RESERVED FOR OTHER C	PR FUTURE USE.			
Y N D	Does the patient require positioning of which is expected to last at least one management.	the body in ways not feasible with an ordinary bed dunonth?	e to a medical condition		
Y N D		tion of pain, positioning of the body in ways not feasi			
YND	4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?				
Y N D	5. Does the patient require traction which				
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?				
Y N D	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?				
		THAN DUNCICIAN (Plans Prism)			
NAME OF PERSON A NAME:	ANSWERING SECTION B QUESTIONS, IF OT	HER THAN PHYSICIAN (Please Print): TITLE:			
PHYSICIAN NAME, A	ADDRESS (Printed or Typed)				
		PHYSICIAN'S UPIN:			
		PHYSICIAN'S TELEPHONE #: (•		
		Till didnit of teach from the	Rev		

SECTION A:

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the <u>longest</u> warranty <u>Length</u> (months or years) should be indicated that applies to any <u>one</u> of the warranty types on that item. List only the one warranty <u>Type</u> that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Indicate the telephone number where the physician can be contacted (preferably a number where records would be accessible pertaining to this patient) if more information is needed.

	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER	DMERC 01.02A
	Certificate Of Medical Necessity: HOSPITAL BEDS	PAGE 2 OF 2
PATIENT NAME:	HICN:	
SECTION C	Confirmation Of Physician Order / Narrative Description Of Equipment And C	ost
(1) <u>Narrative</u> diagnos (3) Supplier's charge:	es given by physician; (2) <u>Narrative</u> description of all items, accessories and option and (4) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option.	s ordered;
	(See Instructions On Back)	
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SECTION D	Physician Attestation and Signature/Date	
I, the patient's physician, certifit the medical necessity of hereto, has been reviewed and	ly that I have received Sections A, B, and C of this Certificate Of Medical Necessity (including of these items for this patient. I have reviewed the answers in Section B of this form. Any statement signed by me. The foregoing information is true, accurate and complete, to the best of my knowled oncealment of material fact may subject me to civil or criminal liability.	t on my ledemead adached
	PHYSICIAN'S SIGNATURE DAT	E/

SECTION C:

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs, (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A. B. C and D. (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Effective 10/01/95

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 01.02B

	Certificate Of Medical Necess	ity: SUPPORT SURFACES PAGE 1 OF 2				
SECTION A	Certification Type/Date: INITIA	L// REVISED//				
PATIENT NAME, ADD	RESS, TELEPHONE and HIC NUMBER SUF	PLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER				
	HICN(
LACE OF SERVICE	PTC	OB/				
AME and ADDRESS	of FACILITY if applicable (see reverse):	ICPCS REPLACEMENT WARRANTY				
	0	ODES (check if applicable) (see reverse) Length (months) Type (1-4)				
		Length (months)				
ECTION B	information Below May Not Be Completed Anyone in A Financial Relationship With Ti	By The Supplier Of The Items/Supplies, Nor e Supplier.				
T. LENGTH OF	EED (# OF MONTHS): 1-99 (98=LIFETIME) DIA	GNOSIS CODES (ICD-9):				
ANSWERS	ANSWER QUESTIONS 12 13 & 21 FOR ALTER	ATING PRESSURE PADS OR MATTRESSES: 13-22 FOR AIR				
ANSWENS	FLUIDIZED BEDS					
	(Circle Y for Yes, N for No	or D for Does Not Apply, Unless Otherwise Noted)				
	QUESTIONS 1-11, 17 AND 18 ARE RESERV	D FOR OTHER OR FUTURE USE.				
Y N D	12. Is the patient highly susceptible to decubiture	ulcers?				
Y N D	13. Are you supervising the use of the device?					
Y N D	14. Does the patient have coexisting pulmonary	disease?				
Y N D	15. Has a conservative treatment program beer	tried without success?				
Y N D	16. Was a comprehensive assessment perform	ed after failure of conservative treatment?				
Y N D	19. Are open, moist dressings used for the trea					
Y N D		20. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?				
	24 Provide the stage and size of each pressur	sulcer necessitating the use of the overlay, mattress or bed. If				
	the patient is highly susceptible to decubitu	ulcers, but currently has no ulcer present, place a "9" under ulcer #1.				
	Pressure Ulcer Ulcer	t 1 Ulcer#2 Ulcer#3				
	Stage:					
_	Max. Length (cm):					
	Max. Width (cm):					
1 2 3	22 Over the past month, the patient's ulcer(s)	nas/have: 1) Improved 2) Remained the same 3) Worsened?				
	N ANSWERING SECTION B QUESTIONS, IF OTHER					
	N ANSWERING SECTION & QUESTIONS, IF OTHER	TITLE:				
NAME:						
PHYSICIAN NAM	, ADDRESS (Printed or Typed)					
		·				
		DENCE CLANCE LIGHT.				
		PHYSICIAN'S UPIN:				
		PRISICIAN S UFIN.				

SECTION A:

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked. "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL." and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor, (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS:

If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Indicate the telephone number where the physician can be contacted (preferably a number where records would be accessible pertaining to this patient) if more information is needed.

DMERC 01.02B DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER Effective 10/01/95 PAGE 2 OF 2 Certificate Of Medical Necessity: SUPPORT SURFACES HICN: PATIENT NAME: Confirmation Of Physician Order / Narrative Description Of Equipment And Cost **SECTION C** (1) <u>Narrative</u> diagnoses given by physician; (2) <u>Narrative</u> description of all items, accessories and options ordered; (3) Supplier's charge; and (4) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

Physician Attestation and Signature/Date SECTION D

I, the patient's physician, certify that I have received Sections A, B, and C of this Certificate Of Medical Necessity (including charges for items ordered). certify the medical necessity of these items for this patient. I have reviewed the answers in Section B of this form. Any statement on my letterhead attached hereto, has been reviewed and signed by me. The foregoing 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.

> DATE _ PHYSICIAN'S SIGNATURE _

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION C:

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs. (3) the supplier's charge for each item, option, accessory, supply and drug, and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items

ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Effective 10/01/95

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 02.02A

	Certifica	ate Of Medical Neces	sity: MOTO	RIZED WHEELCHAIR	S	PAGE 1 OF 2
SECTION A	Certificatio	n Type/Date:	NITIAL/_	REVISED _		
PATIENT NAME, ADDRESS, T	ELEPHONE and HIC	UMBER	SUPPLIER NA	ME. ADDRESS, TELEPHO	NE and NSC NUMBER	
					•	
	HICN		<u> </u>	NSC#		
PLACE OF SERVICE	_		PT DOB/_	/; HT(in.)	(optional); WT(lbs	i.); Sex(M/F)
NAME and ADDRESS of FACIL	ITY if applicable (see r	everse):	HCPCS	REPLACEMENT	WARRANT	
			CODES	(check if applicable)	(see reverse Length (months)	7 Type (1-4)
				<u></u>		
		.*			·	
	•			·		
SECTION B	Information Balo	ow May Not Be Compl	eted By The S	upplier Of The Items/S	ıpplies, Nor	
	Anyone in A Fina	encial Relationship W	ith The Suppli	er.		
EST. LENGTH OF NEED (#	OF MONTHS):	1-99 (99=LIFETIME)	DIAGNOSIS C	CODES (ICD-9):		
EST. EEROTT OF THE STATE	-	T	4		AID DASE A 18 EOD W	HEEL CHAIR
ITEM ADDRESSED	ANSWERS	OPTIONS/ACCESSO		OTORIZED WHEELCH	AIR BASE, 4-18 FOR WI	TEELCHAIN
		1		u Désa Dana Mat A	ti- Union Othonico N	loted)
		(Circle Y	for Yes, N for I	No, or U for Does Not A	pply, Unless Otherwise N	10(84)
		Questions 3, 9, 11 -	14, and 17, re	served for other or futur	e use	
Motorized Whichr Base	YND	1. Does the patient	have severe	weakness of the upper e	extremities due to a neuro	ologic, muscular
MOROTIZED WITHOUT DUSC		or cardiopulmon	ary disease/co	naition?		
Motorized Whichr Base	Y N D	2. Have all types o	f manual whee	Ichairs been considered	and ruled out?	.,
Motorized Whichr Base	Y N D	4. Does the patient	t require and u	se a wheelchair to move	e around in their residence	e?
and Accessories		<u> </u>				
Reclining Back	YND	5. Does the patien				
Reclining Back	Y N D	6. Does the patien				<u></u>
Reclining Back	Y N D	7. Does the patien	t have a trunk	cast or brace that require	es a rectining back featu	re for
		positioning?			Leadition which prove	te 90 degree
Elevating Leg Rest	YND	8. Does the patient flexion of the kn	it have a cast, nee, or does the	prace or musculoskelet e patient have significar	al condition, which prevent tedema of the lower ext	remities that
		requires an elev	rating leg test?			
Reclining Back	YND	10. Does the patient have excessive extensor tone of the trunk muscles?				
Adjustable Height Armrest	YND	15. Does the patier	nt have a need	for arm height different	than that available using	non-adjustable
		ams?			tue es mare timos durins	the day?
Reclining Back	YND				two or more times during	
Reclining Back; Adjustable HT. Armrest		the next hour)			and in the wheelchair? (1	-24) (Round up
NAME OF PERSON ANSW	ERING SECTION I	B QUESTIONS, IF OTH	IER THAN PH	YSICIAN (Please Print):		
NAME:				TITLE:		
	ESS (Brinted or T	vned)				
PHYSICIAN NAME, ADDR	ESS (FIIIMED OF I)	, boni	1.			
			010	CICIAN'S LIDIN.		
			PHT	SICIAN'S UPIN:		
				CICIANIC TEL EDUCNE	: 44. /	
	٠.		PHY	SICIAN'S TELEPHONE	*· L -	
						Rev. 7

SECTION A:

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked. "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female), height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME,

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Indicate the telephone number where the physician can be contacted (preferably a number where records would be accessible pertaining to this patient) if more information is needed.

Effective 10/01/95			MENT REGIONA		DMERC 02.02
	Certificate Of I	Medical Necessity:	MOTORIZED WH	EELCHAIRS	PAGE 2 OF
ATIENT NAME:			HICN:		
ECTION C	Confirmation Of Ph	ysician Order / Na	rrative Description	on Of Equipment And Co	st
(1) <u>Narrative</u> diagnos (3) Supplier's charge	ses given by physician; ; and (4) Medicare Fee	(2) <u>Narrative</u> des Schedule Allowar	cription of all items ace for <u>each</u> item, a	, accessories and options accessory, and option.	ordered;
•	·	(See Instruction	ns On Back)	•	
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ECTION D	Phy	sician Attestation	n and Signature/D	ate	
certify the medical necessity	tify that I have received So	actions A, B, and C ont. I have reviewed to	e, accurate and comp	fedical Necessity (including c B of this form. Any statement lete, to the best of my knowle	

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION C:

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 02.02B

	Certif	icate Of Medical Nec	essity: MAN	JAL WHEELCHAIRS		PAGE 1 OF 2
SECTION A	Certificatio	n Type/Date: IN	NITIAL/_			
PATIENT NAME, ADDRESS, T	ELEPHONE and HIC	NUMBER	SUPPLIER NAI	ME, ADDRESS, TELEPHO	NE and NSC NUMBER	
(HICN		()	NSC#		
			27.202 /		(optional); WT	
PLACE OF SERVICE NAME and ADDRESS of FACIL			HCPCS CODES	REPLACEMENT (check if applicable)	WARRA (see rev Length (months)	INTY
SECTION B	Information Beid Anyone In A Find	ow May Not Be Comple ancial Relationship Wi	eted By The S th The Suppli	upplier Of The Items/S er.	upplies, Nor	
EST. LENGTH OF NEED (# 0	OF MONTHS):	1-99 (99=LIFETIME)	DIAGNOSIS C	ODES (ICD-9):		
ITEM ADDRESSED	ANSWERS	WHEELCHAIR OPTIO	ONS/ACCESS			
		,		No. or D for Does Not A		se Noted)
				and 21 reserved for oth		407003
Manual Whichr Base And All <u>Accessories</u>	YND			use a wheelchair to mo	ve around in their res	dence?
Reclining Back	YND	5. Does the patier				
Reclining Back	YND	6. Does the patier				
Reclining Back	Y N D	positioning?		cast or brace that requ		
Elevating Leg Rest	YND	requires an ele	vating leg rest			revents 90 degree r extremities that
Reclining Back	YND			sive extensor tone of the		
Adjustable HT. Armrest	YND	ams?		for arm height differen		
Reclining Back	YND			in a recumbent positio		
Reclining Back; Adjustable HT. Armrest; Any Type Ltwt. Whichr		to the next hou	Jr)	es the patient usually s		
Any Type Ltwt. Whichr	YND	20. Is the patient a manual wheel	able to adequa chair?	tely <u>self-propei</u> (without	being pushed) in a s	tandard weight
Any Type Ltwt. Whichr	YND) is "No", would the pati e wheelchair which has		атегу <u>ѕеп-ргорег</u>
NAME OF PERSON ANSW	ERING SECTION I	B QUESTIONS, IF OTH	IER THAN PH' —	YSICIAN (Please Print): TITLE:		
PHYSICIAN NAME, ADDR	ESS (Printed or T	yped)				
			BUV	SICIAN'S UPIN:		
						
			PHY	SICIAN'S TELEPHONE	: #: (

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT. WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest:

(1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reas in for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

(1) Narrative diagnoses give	Certificate Of Medical Necessity: MANUAL WHEELCHAIRS HICN: Firmation Of Physician Order / Narrative Description Of Equipment And Cost	
SECTION C Conf	Firmation Of Physician Order / Narrative Description Of Equipment And Cost	
(1) Narrative diagnoses give	INITIALIUM OF LIMAIOMI COMPTONIANTA ATTACAMA TO TO THE STATE OF THE ST	
(1) Narrative diagnoses give	en by physician; (2) Narrative description of all items, accessories and options order	ed;
(3) Supplier's charge; and ((4) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option.	
	(See Instructions On Back)	
-		
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		•
- -		
-		
SECTION D	Physician Attestation and Signature/Date	

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 03.02

	Certificate Of Medical Necessity:	CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) PAGE 1 OF 2
SECTION A	Certification Type/Date:	INITIAL/_/ REVISED//_
PATIENT NAME, ADDRE	SS. TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
		NSC #
	HICN	
PLACE OF SERVICE		PT DOB/: Sex(M/F) HCPCS REPLACEMENT WARRANTY
NAME and ADDRESS of	FACILITY if applicable (see reverse):	CODES (check if applicable) (see reverse)
÷		Length (months) Type (1-4)
	· .	
		- Control of the Mary (Complian Mary
SECTION B	Information Below May Not Be Co Anyone in A Financial Relationship	ompleted By The Supplier Of The Items/Supplies, Nor ip With The Supplier.
EST. LENGTH OF NEE	D (# OF MONTHS): 1-99 (99=LIFET)	
	ANSWER QUESTIONS 12 AND 14 FOR	
ANSWERS	1	N for No. or D for Does Not Apply, Unless Otherwise Noted)
	(Circle Y for Yes,	N for No. or D for Does Not Apply, Offices Officialise Rocky
-	Questions 1 - 11, and 13, reserved for o	other or future use.
	12. How many episodes of apnea lastin sleep? (Number of episodes) (If gre	ng greater than 10 seconds does the patient have during 6-7 hours of recorded eater than 99, enter 99.)
Y N D	14. Does the patient have obstructive s	sleep apnea?
	•	
-		
ı		
NAME OF PERSON	ANSWERING SECTION B QUESTIONS, IF	OTHER THAN PHYSICIAN (Please Print):
NAME:		TITLE:
	DDRESS (Printed or Typed)	
PHISICIAN NAME, A	(DDUCEGO (Linimo or 13 boot)	
		1
		PHYSICIAN'S UPIN:
ĺ		PHYSICIAN'S TELEPHONE #: ()
		Rev 7/

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL." and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL." and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the hame and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME,

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/01/95	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER	DMERC 03.02				
	Certificate Of Medical Necessity: CONTINUOUS POSITIVE AIRWAY PRESSURE (CR	PAP) PAGE 2 OF 2				
ATIENT NAME:	IT NAME: HICN:					
ECTION C	Confirmation Of Physician Order / Narrative Description Of Equipment And Cost					
 Narrative diagnoses given by physician; Narrative description of all items, accessories, options and supplies orders Supplier's charge; and (4) Medicare Fee Schedule Allowance for each item, accessory, option and supply. 						
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	Physician Attestation and Signature/Date					
certify the medical necess	pertify that I have received Sections A, B, and C of this Certificate Of Medical Necessity (includity of these items for this patient. I have reviewed the answers in Section B of this form. Any state and signed by me. The foregoing information is true, accurate and complete, to the best of my lor concealment of material fact may subject me to civil or criminal liability.					
	PHYSICIAN'S SIGNATURE	DATE/				
•	(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)					

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug. If applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 04.02B

	Certificate Of Medical Nece	sity: LYMPHEDEMA PUMPS	PAGE 1 OF 2
SECTION A	•	TAL// REVISED/_/_	
PATIENT NAME, ADDR	ESS, TELEPHONE and HIC NUMBER	UPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER	₹
	HICN) - NSC #	
PLACE OF SERVICE		T DOB / _ /: Sex (M/F)	
_	FACILITY if applicable (see reverse):	HCPCS REPLACEMENT WARF	PANTY
	.,		everse) Type (1-4)
		Length (months)	
•			
	,		
SECTION B	Information Below May Not Be Comple Anyone In A Financial Relationship Wit	d By The Supplier Of The Items/Supplies, Nor The Supplier.	·
ST. LENGTH OF NE	ED (# OF MONTHS): 1-99 (99=LIFETIME)	IAGNOSIS CODES (ICD-9):	
ANSWERS	ANSWER QUESTIONS 7-11 FOR LYMPHEI	EMA PUMP	
	l l	r Yes, N for No, or D for Does Not Apply)	
-	(Gildie 1		
	QUESTIONS 1 - 6, reserved for other or future		
Y N D	7. Does the patient have a malignant tumor	vith obstruction of the lymphatic drainage of an extremit	y?
Y N D	8. Has the patient had surgery or radiation	at interrupted normal lymphatic drainage or is there a c	ongenital abnormalit
, ,	of lymphatic drainage?		
YND	of lymphatic drainage?	of chronic venous insufficiency with edema and/or veno	
	of lymphatic drainage?		
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?		us ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	us ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	us ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	us ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	us ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	ous ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	ous ulcers?
Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or veno	us ulcers?
Y N D Y N D Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressu	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of t	us ulcers?
Y N D Y N D Y N D	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema?	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of t	us ulcers?
Y N D Y N D Y N D NAME OF PERSON	of lymphatic drainage? 9. Is the device prescribed for the treatment 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressure of the pressure of the pressure of the physician prescribed the pressure of the pressure of the physician prescribed the p	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of the state of	us ulcers?
Y N D Y N D Y N D NAME OF PERSON	of lymphatic drainage? 9. Is the device prescribed for the treatmen 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressu	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of the state of	us ulcers?
Y N D Y N D Y N D NAME OF PERSON	of lymphatic drainage? 9. Is the device prescribed for the treatment 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressure of the pressure of the pressure of the physician prescribed the pressure of the pressure of the physician prescribed the p	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of the state of	ous ulcers?
Y N D Y N D Y N D NAME OF PERSON	of lymphatic drainage? 9. Is the device prescribed for the treatment 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressure of the pressure of the pressure of the physician prescribed the pressure of the pressure of the physician prescribed the p	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of the state of	us ulcers?
Y N D Y N D Y N D NAME OF PERSON	of lymphatic drainage? 9. Is the device prescribed for the treatment 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressure of the pressure of the pressure of the physician prescribed the pressure of the pressure of the physician prescribed the p	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of the state of	us ulcers?
Y N D Y N D Y N D NAME OF PERSON	of lymphatic drainage? 9. Is the device prescribed for the treatment 10. Is there intractable lymphedema? 11. Has the physician prescribed the pressure of the pressure of the pressure of the physician prescribed the pressure of the pressure of the physician prescribed the p	of chronic venous insufficiency with edema and/or venous to be used and the frequency and duration of use of the state of	ous ulcers?

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked. "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/01/95	DURABLE	MEDICAL EC	UIPMENT REGIO	ONAL CARR	IER	DMERC 04.02B
	Certificate	e Of Medical Nec	essity: LYMPHEDE	MA PUMPS		PAGE 2 OF 2
PATIENT NAME:			HICN:			
SECTION C	Confirmation Of	Physician Orde	er / Narrative Desc	ription Of Eq	uipment And Co	st
(1) Narrative diagno (3) Supplier's charge	ses given by physicia e; and (4) Medicare	an; (2) <u>Narrativ</u> Fee Schedule A	e description of all i	items, accessory em, accessory	ories and options or, and option.	ordered;
			ructions On Back)			
			•			
• .						
•						
		•				
SECTION D			tation and Signati			
I, the patient's physician, cei I certify the medical necessity hereto, has been reviewed at any falsification, omission, or	y of these items for this p nd signed by me. The fo	patient. I nave revi precoing information	n is true, accurate and	complete, to the		
	PHYS	ICIAN'S SIGNATU	RE		DATE	
	(SIGN	ATURE AND DATE	STAMPS ARE NOT A	CCEPTABLE)		

Rev. 7/25/95

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug. If applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION: The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items

ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Effective 10/01/95	DURABLE MEDICAL EC	QUIPMENT REGIONAL CARRIER	DMERC 04.02C
	Certificate Of Medical Nece	ssity: OSTEOGENESIS STIMULATOR	PAGE 1 OF 2
SECTION A	Certification Type/Date:	NITIAL// REVISED/_	
PATIENT NAME, ADDR	ESS. TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and	d NSC NUMBER
	•		
	HICN	NSC#	
PLACE OF SERVICE _		PT DOB / / : Sex (M/F)	
NAME and ADDRESS of	FACILITY if applicable (see reverse):	HCPCS REPLACEMENT CODES (check if applicable)	WARRANTY (see reverse) ength (months) Type (1-4)
	•		
SECTION B	information Below May Not Be Comp Anyone in A Financial Relationship V	eleted By The Supplier Of The Items/Supplier/ With The Supplier.	ss, Nor
EST. LENGTH OF NE	ED (# OF MONTHS): 1-99 (99=LIFETIME	DIAGNOSIS CODES (ICD-9):	
ANSWERS	ANSWER QUESTIONS 12-15 FOR OSTE	OGENESIS STIMULATOR.	
	I	for No, or D for Does Not Apply, Unless Other	erwise Noted)
-	QUESTIONS 1 - 11, and 16, reserved for o	ther or future use.	
Y N D	12. Does the patient have a non-union of	a long-bone fracture?	
Y N D	13. Does the patient have a failed fusion?		
Y N D	14. Does the patient have a congenital ps	eudoarthrosis?	
	15. How many months ago did the patien (Enter number of months 1-99)	sustain the long-bone fracture being treated	or have the fusion that has failed?
-			
			•
	•		
-			
NAME OF PERSON	ANSWERING SECTION B QUESTIONS, IF OT		
NAME:		TITLE:	
PHYSICIAN NAME,	ADDRESS (Printed or Typed)		
·			
		PHYSICIAN'S UPIN:	
İ			
	·	PHYSICIAN'S TELEPHONE #: (

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked. "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest:

(1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

DMERC 04.02C

Effective 10/01/95	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER	DMERC 04.020
	Certificate Of Medical Necessity: OSTEOGENESIS STIMULATOR	PAGE 2 OF 2
ATIENT NAME:	HICN:	-
ECTION C	Confirmation Of Physician Order / Narrative Description Of Equipment And Cost	
(1) Narrative diagnose (3) Supplier's charge:	es given by physician; (2) <u>Narrative</u> description of all items, accessories and options or and (4) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option.	dered;
	(See Instructions On Back)	
	·	
· .		
•		
•		
	Physician Attestation and Signature/Date	
ertify the medical necessity	tify that I have received Sections A, B, and C of this Certificate Of Medical Necessity (including char of these items for this patient. I have reviewed the answers in Section B of this form. Any statement on id signed by me. The foregoing information is true, accurate and complete, to the best of my knowledge concealment of material fact may subject me to civil or criminal liability.	ges for items order my letterhead attac e, and I understand

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D, (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 06.02

Cert	ificate Of Medical Necessity: TRANSCUT					
ECTION A	,,,	NITIAL/ REVISED/				
TIENT NAME, ADDRES	S. TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER				
	HICK	NSC#				
CE OF SERVICE		PT DOB / /: Sex(M/F)				
	ACILITY if applicable (see reverse):	HCPCS REPLACEMENT WARRANTY				
AE and ADDRESS OFF	(CIET I II applicable (Cie I Cie I C	CODES (check if applicable) (see reverse)				
		Length (months) Type (1-4)				
		eted By The Supplier Of The Items/Supplies, Nor				
CTION B	Anyone in A Financial Relationship Wi	ith The Supplier.				
L ENGTH OF NEED		DIAGNOSIS CODES (ICD-9):				
LENGTH OF NEED						
ANSWERS	ANSWER QUESTIONS 1 - 6 FOR RENTAL	L OF TENS, AND 3 - 12 FOR PURCHASE OF TENS.				
	(Circle Y for Yes, N f	for No, or D for Does Not Apply, Unless Otherwise Noted)				
Y N D	Does the patient have acute post-opera	itive pain?				
//	2. What is the date of surgery resulting in					
Y N D	3. Does the patient have chronic, intractab					
[months]	4. How long has the patient had intractable pain? (Enter number of months, 1 - 99.)					
		ny of the following conditions? (Circle appropriate number)				
1 2 3 4 5	1 - Headache 2 - Visceral abdo	m as distriction of the same				
	4 - Temporomandibular joint (TMJ)					
Y N D	6. Is there documentation in the medical refailed?	record of multiple medications and/or other therapies that have been tried and				
Y N D	7. Has the patient received a TENS trial?					
Began/Ended	8. What are the dates that trial of TENS u					
		•				
		the state of the trial period?				
! <u>!</u>		the patient at the end of the trial period?				
1 2 3	10. How often has the patient been using t 1 = Daily 2 = 3 to 6 days per we	eek 3 = 2 or less days per week				
Y N D	1 TENS is warranted?	e has been a significant improvement in the pain and that long term use of a				
2 4	(Circle appropriate number)	electrodes) routinely needed and used by the patient at any one time: $2 = 2$ leads $4 = 4$ leads				
	NSWERING SECTION B QUESTIONS, IF OTI	HER THAN PHYSICIAN (Please Print):				
AME OF PERSON A		TITLE:				
AME OF PERSON AI NAME:						
NAME:	DRESS (Printed or Typed)					
NAME:	ODRESS (Printed or Typed)					
NAME:	ODRESS (Printed or Typed)					
NAME:	ODRESS (Printed or Typed)					
NAME:	ODRESS (Printed or Typed)	PHYSICIAN'S UPIN:				
NAME:	ODRESS (Printed or Typed)	PHYSICIAN'S UPIN:				

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the <u>longest</u> warranty <u>Length</u> (months or years) should be indicated that applies to any <u>one</u> of the warranty types on that item. List only the one warranty <u>Type</u> that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 cr. :es).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physicial therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 06.02

ATIENT NAME: _	ertificate Of Medical Necessity: TRANSCUTANEOU	HICN:	
			y And Cost
ECTION C	Confirmation Of Physician Order / Narr		
(1) Narrative dia (3) Supplier's ch	gnoses given by physician; (2) <u>Narrative</u> descrip arge; and (4) Medicare Fee Schedule Allowance	tion of all items, accessories, option for <u>each</u> item, accessory, option	ions and supplies ordered, and supply
	(See Instructions	On Back)	
·			
ECTION D	Physician Attestation a	and Signature/Date	
the patient's physicial sertify the medical ne	in, certify that I have received Sections A, B, and C of to cessity of these items for this patient. I have reviewed the wed and signed by me. The foregoing information is true, ion, or concealment of material fact may subject me to civil	his Certificate Of Medical Necessity of answers in Section B of this form. An accurate and complete, to the best of	(including charges for items order y statement on my letterhead attai my knowledge, and I understand
	PHYSICIAN'S SIGNATURE	•	
	(SIGNATURE AND DATE STAMP		

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A. B. C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items

ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 07.02A

	Certificate Of Medical Nec	cessity: SEAT	LIFT MECHANISM		PAGE 1 OF 2
ECTION A	Certification Type/Date:	NITIAL/_	/ REVISED	<u></u>	
ATIENT NAME, ADDRES	S. TELEPHONE and HIC NUMBER	SUPPLIER NAM	E, ADDRESS, TELEPHON	E and NSC NUMBER	
				•	
	HICN		NSC#_		
ACE OF SERVICE		PT DOB /	/ Sex (M/F)		
NAME and ADDRESS of FACILITY if applicable (see reverse):		HCPCS	REPLACEMENT	WARRA	NTY
are and more than the	,	CODES	(check if applicable)	(see rev	
				Length (months)	Type (1-4)
					 .
	·	<u> </u>			
CTION B	Information Below May Not Be Compl Anyone In A Financial Relationship W	leted By The Su /ith The Supplie	ipplier Of The Items/Su न.	pplies, Nor	
T. LENGTH OF NEED					
ANSWERS	ANSWER QUESTIONS 1 -5 FOR SEAT LIF	FT MECHANISM	1		
	(Circle Y	for Yes, N for	No, or D for Does Not A	Apply)	
Y N D	Does the patient have severe arthritis or	of the hip or kne	?		
Y N D	Does the patient have a severe neuromuscular disease?				
Y N D	3. Is the patient completely incapable of si	standing up from	a regular armchair or a	ny chair in his/her ho	ome?
Y N D	4. Once standing, does the patient have the				
Y N D	Have all appropriate therapeutic modali (e.g., medication, physical therapy) been seen as a second control of the second contro	lities to enable the en tried and faile	ne patient to transfer from	m a chair to a standi mented in the patien	ing position t's medical records
				,	
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			•		
	•		•		
		UED TUAN BIN	CICIAN (Please Print)		·
AME OF PERSON A	NSWERING SECTION B QUESTIONS, IF OT	HER IMANIPHI			
NAME:			TITLE:		
YSICIAN NAME. A	DDRESS (Printed or Typed)				
			•		
		1			
		БПА	SICIAN'S UPIN:		
-		1			
		PHY	SICIAN'S TELEPHONE	#: (
					Rev

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL." and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL." and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested:

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest:

(1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes. "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

	Certificate Of Medical Necessity: SEAT LIFT MECHANISM PA	GE 2 OF 2
ATIENT NAME:	HICN:	
ECTION C	Confirmation Of Physician Order / Narrative Description Of Equipment And Cost	
(1) Narrative diagno	oses given by physician; (2) Narrative description of all items, accessories and options ordered; ge; and (4) Medicare Fee Schedule Allowance for each item, accessory, and option.	
(a) Supplier's charg	(See Instructions On Back)	
		•
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ECTION D	Physician Attestation and Signature/Date	
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(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE:

After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 07.02B

SECTION A Certification Type/Date: INITIAL / REVISED _ /	
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (see reverse): PT DOB	
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (see reverse) PT DOB	
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (see reverse): PT DOB	
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (see reverse): PT DOB	
PLACE OF SERVICE NAME and ADDRESS of FACILITY if applicable (see reverse): PT DOB	
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Anyone in A Financial Relationship With The Supplier. EST. LENGTH OF NEED (# OF MONTHS):1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): ANSWERS ANSWER QUESTIONS 6 - 14 FOR POWER OPERATED VEHICLE (POV)	e (1 -4)
Anyone in A Financial Relationship With The Supplier. ST. LENGTH OF NEED (# OF MONTHS):1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): ANSWERS ANSWER QUESTIONS 6 - 14 FOR POWER OPERATED VEHICLE (POV) (Circle Y for Yes, N for No, or D for Does Not Apply) Questions 1 - 5, and 9 - 11, reserved for other or future use. Y N D 6. Does the patient require a POV to move around in their residence? Y N D 7. Have all types of manual wheelchairs (including lightweights) been considered and ruled out? Y N D 8. Does the patient require a POV only for movement outside their residence? Y N D 12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or	<u> </u>
Anyone in A Financial Relationship With The Supplier. ST. LENGTH OF NEED (# OF MONTHS):1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): ANSWERS	
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12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or	
Y N D 13. Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?	
Y N D 14. Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surger	у,
Y N D neurology, or rheumatology?	
CONTROL THAN DUVCICIAN (Places Drint)	
IAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):	
NAME:TITLE:	
PHYSICIAN NAME, ADDRESS (Frinted or Typed)	
PHYSICIAN'S UPIN:	_
PHYSICIAN'S TELEPHONE #: ()	

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked. "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must print his/her name and give his/her professional title where indicated. If the physician is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS: Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

	Certificate Of Medical Necessity: POWER OPERATED VEHICLE (POV)	PAGE 2 OF 2
ATIENT NAME:	HICN:	
ECTION C	Confirmation Of Physician Order / Narrative Description Of Equipment And Cost	
(1) Narrative diagnoses	s given by physician: (2) Narrative description of all items, accessories and options ordere	ed,
(3) Supplier's charge;	and (4) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option.	
	(See Instructions On Back)	
•		
		·
ECTION D	Physician Attestation and Signature/Date	
certify the medical necessity of	If that I have received Sections A, B, and C of this Certificate Of Medical Necessity (including charges if these items for this patient. I have reviewed the answers in Section B of this form. Any statement on my lisigned by me. The foregoing information is true, accurate and complete, to the best of my knowledge, an incealment of material fact may subject me to civil or criminal liability.	
	PHYSICIAN'S SIGNATURE DATE	
	(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)	

Rev. 7/25/95

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician. (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug. if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

TELEPHONE #: (

Effective 10/01/95	DURABLE MEDICAL EQ	UIPMENT REGIONAL CARRIER DMERC 08.02
· ·	DMERC Information Form	: IMMUNOSUPPRESSIVE DRUGS
	ALL INFORMATION ON THIS FOR	M MAY BE COMPLETED BY THE SUPPLIER
Certification Typ	e/Date: INITIAL / REV	/ISED//
PATIENT NAME, ADDRES	S, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
	unos)	NSC#
	· · · · · · · · · · · · · · · · · · ·	PT DOB / /: Sex (M/F)
PLACE OF SERVICE NAME and ADDRESS of FA	ACILITY if applicable (see reverse):	
	AND AND AN AND AN AND AND AND AND AND AN	CODES): V42.1 (HEART); V42.7 (LIVER); V42.0 (KIDNEY);
	SIS CODES (ICD-9) (CIRCLE APPROPRIATE	V42.8 (OTHER-SPECIFY)
_ V42	.6 (LUNG); V42.8 (BONE MARROW);	
ANSWERS	ANSWER QUESTIONS 1 - 5 AND 8 - 12 FO	
		or No, or D for Does Not Apply, Unless Otherwise Noted)
	Questions 6 and 7, reserved for other or for	
	What are the drug(s) prescribed and the d HCPCS MG	osage and frequency of administration of each? TIMES PER DAY
	1	
•	2	
	3	<u> </u>
Υ ١٠'	Has the patient had an organ transplant t	hat was covered by Medicare?
Enter Correct	5. Which organ(s) have been transplanted?	(List most recent transplant) (May enter up to three different organs).
Number(s)	1	Heart Liver
	3 -	Kidney Bone Marrow
	1	Lung
	8. Name of facility where transplant was pe	rformed.
	9. City where facility is located.	
	10. State where facility is located.	
	11. On what date was the patient discharged	from the hospital following this transplant surgery?
YN	12. Was there a prior transplant failure of thi	s same organ?
PHYSICIAN NAME, AD	Printed or Typed)	SUPPLIER'S SIGNATURE DATE (A Stamped Signature is Not Acceptable)
UPIN:		PRINT NAME

ALL INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the

effective date of the order change in the space marked, "REVISED."

PATIENT INFORMATION:

Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the drug is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage

Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female).

TRANSPLANT DIAGNOSIS CODES: Circle the appropriate ICD-9 code reflecting the organ transplant for which this immunosuppressive drug is being prescribed. If an organ other than those listed was transplanted, circle V42.8 and print or type in the name of the organ in the parentheses.

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the drugs ordered, circling "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

PHYSICIAN NAME,

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably a number where records would

be accessible pertaining to this patient) if more information is needed.

SUPPLIER'S SIGNATURE:

The person who completed this form and accepts responsibility for the accuracy and completeness of the information

contained on this form, signs and dates this form. Signature and date stamps are not acceptable.

PRINTED NAME:

The person signing the form, legibly prints or types his/her name.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 09.02

	Certificate Of Medical Nec	essity: EXTERNAL INFUSION PUMP	PAGE 1 OF 2
SECTION A	Certification Type/Date:	INITIAL// REVISED/_/_	
PATIENT NAME, ADDRES	SS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUM	BER
			•
· · · · · · · · · · · · · · · · · · ·	HICN	NSC#	
PLACE OF SERVICE		PT DOB / / Sex (M/F)	
	FACILITY if applicable (see reverse):		ARRANTY
	<i>*</i>	CODES (check if applicable) (s Length (mont	<i>ee reverse)</i> hs) Type (1-4)
,	·		
			_
	•		
SECTION B	Information Below May Not Be Com Anyone In A Financial Relationship	pleted By The Supplier Of The Items/Supplies, Nor Mith The Supplier.	
ST. LENGTH OF NEE	D (# OF MONTHS): 1-99 (99=LIFETIMI	DIAGNOSIS CODES (ICD-9):	
ANSWERS	ANSWER QUESTIONS 1 - 7 FOR EXTER	NAL INFUSION PUMP.	,
MNSVVERS	■	for No, or D for Does Not Apply, Unless Otherwise Not	ed)
1 3 4	Circle number of pump which has bee Sternal inflision nump (non-dispo	n prescribed: sable); 2 - Reserved for other or future use;	
, 5 4	3 - Implantable infusion pump; 4 - Dis	posable infusion pump (e.g., elastomeric)	
HCPCS CODE:	2. Provide the HCPCS code for the drug	that requires the use of the pump.	
, , <u>, , , , , , , , , , , , , , , , , </u>			
	3. If non-specific code was used to answ	ver questions, <u>print</u> name of drug.	
1 3 4	Circle number for route of administrat 1 - Intravenous; 2 - Reserved for other	ion? er or future use; 3 - Epidural; 4 - Subcutaneous	
1 2 3	5. Circle number for method of administ	ration? 1 - Continuous; 2 - Intermittent; 3 - Bolus	
	6. What is the total duration of drug infu		
Y N D	Does the patient have intractable car narcotic analgesic regimen or is the patients.	ncer pain which has failed to respond to an adequate ora patient unable to tolerate oral/transdermal narcotics?	ıl/transdermal
-			
			,
NAME OF PERSON A	INSWERING SECTION B QUESTIONS, IF O	THER THAN PHYSICIAN (Please Print):	·
NAME:		TITLE:	
PHYSICIAN NAME, A	DDRESS (Printed or Typed)		
L.			
		PHYSICIAN'S UPIN:	
		PHYSICIAN'S TELEPHONE #: ()_	
			Rev.

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the longest warranty Length (months or years) should be indicated that applies to any one of the warranty types on that item. List only the one warranty Type that lasts the longest:

(1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank; if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS:

If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/01/95	DURABLE M	EDICAL EQUIP	MENT REGIONA	L CARRIEF	₹ 	DMERC 09.0
	Certificate Of	Medical Necessity:	EXTERNAL INFU	SION PUMP		PAGE 2 OF 2
ATIENT NAME:			HICN:			_
ECTION C	Confirmation Of Ph	vsician Order / N	arrative Description	on Of Equip	nent And Cost	
(4) Novembro disenses	s given by physician; (2 and (4) Medicare Fee Sc	Narrative descripti	ion of all items, acc	essories, opti	ons, supplies ar	d drugs ordered;
		(See Instructio			•	
					•	
		•				
			•			
•				·		
•		•				
					•	
	•					
		ysician Attestatio	and Signature/	Date		
certify the medical necess	certify that I have received S ity of these items for this pat and signed by me. The fore or concealment of material fa	Sections A, B, and C in interest in the section information is to	of this Certificate Of the answers in Section ue, accurate and com	Medical Neces n B of this form. plete, to the be	sity (including cha Any statement of st of my knowledg	rges for items order n my letterhead attac e, and I understand

Rev. 7/25/95

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician: (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D.

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 10.02A

	Certificate Of Medical Nece	essity: PARENTERAL NUTRITION PAGE 1 OF 2
SECTION A	Certification Type/Date: INITIAL _	/_/_ REVISED _/ / RECERTIFICATION _/_/
ATIENT NAME, ADDRES	SS. TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
	HICN	NSC #
LACE OF SERVICE		PT DOB//: HT(in.); WT(lbs.); Sex(M/F)
AME and ADDRESS of F	ACILITY if applicable (see reverse):	HCPCS REPLACEMENT WARRANTY
		CODES (check if applicable) (see reverse) Length (months) Type (1-4)
-		
ECTION B	Information Below May Not Be Comple Anyone In A Financial Relationship Wi	eted By The Supplier Of The Items/Supplies, Nor
		DIAGHOSIS CODES (ICD-9):
T. LENGTH OF NEEL	· · · · · · · · · · · · · · · · · · ·	
ANSWERS	ANSWER QUESTIONS 1, AND 3 - 5 FOR P	
	(Circle Y for Yes, N fo	or No, or D for Does Not Apply, Unless Otherwise Noted)
	Question 2 reserved for other or future use.	
. Y N	Does the patient have severe permaner to prevent maintenance of weight and st	nt disease of the gastrointestinal tract causing malabsorption severe enough trength commensurate with the patient's overall health status?
	3. Days per week infused? (Enter 1 - 7).	
	4. Formula components:	
	Amino Acid(ml/	/day)concentration %gms protein/day
	Dextrose(ml/c	day)concentration %
	Lipids(ml/day)	days/weekconcentration %
	5. Circle the number for the route of admir	nistration. 2, 4, 5, 6 - Reserved for other or future use.
1 3 7	1 - Central Line; 3 - Hemodialysis A	ccess Line; 7 - Peripherally Inserted Catheter (PIC)
	NSWERING SECTION B QUESTIONS, IF OTH	JED THAN BHYSICIAN (Please Print).
	NSWERING SECTION BIQUESTIONS, IF OTF	TITLE:
NAME:		
HYSICIAN NAME, A	LDRESS (Printed or Typed)	
	•	PHYSICIAN'S UPIN:
		PHYSICIAN'S TELEPHONE #: ()
		Rev

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked. "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL." and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the <u>longest</u> warranty <u>Length</u> (months or years) should be indicated that applies to any <u>one</u> of the warranty types on that item. List only the one warranty <u>Type</u> that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor; (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

ITEM ADDRESSED COLUMN:

(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physicial therapist, nutritionist), or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name and give his/her professional title where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.

PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

	ertificate Of Medical Necessity: PA	RENTERAL NUT	RITION	PAGE 2 OF 2
· · · · · · · · · · · · · · · · · · ·	eruncate Of Medical Necessity.			
PATIENT NAME:		HICN:		
SECTION C Confirma	tion Of Physician Order / Narrativ	ve Description	Of Equipment And	Cost
(1) Narrative diagnoses given by (3) Supplier's charge; and (4) Me	physician; (2) <u>Narrative</u> description dicare Fee Schedule Allowance fo	on of all items, a r <u>each</u> item, acc	ccessories, options a cessory, option and s	and supplies ordered; upply
	(See Instructions On	Back)		
•				
N.				
			•	
		•		
	<u> </u>			
SECTION D I, the patient's physician, certify that I have	Physician Attestation and		·	

PHYSICIAN'S SIGNATURE _

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug. If applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION: The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A. B. C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

DMERC 10.02B

	Certificate Of Medical Nec	cessity: ENTERAL NUTRITION PAGE 1 OF 2
SECTION A C	ertification Type/Date: INITIAL	
PATIENT NAME, ADDRESS, TELE	PHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
· 	4ICN	NSC #
PLACE OF SERVICE		PT DOB/ HT(in.); WT(lbs.); Sex(M/F)
NAME and ADDRESS of FACILITY	if applicable (see reverse):	HCPCS REPLACEMENT WARRANTY
		CODES (check if applicable) (see reverse) Length (months) Type (1-4)
SECTION B	nformation Below May Not Be Comp	leted By The Supplier Of The Items/Supplies, Nor
*	nyone In A Financial Relationship W	
ST. LENGTH OF NEED (# OF		DIAGNOSIS CODES (ICD-9):
ANSWERS		0 10 - 15 FOR ENTERAL NUTRITION
	(Circle Y for Yes	N for No, or D for Does Not Apply, Unless Otherwise Noted)
	Questions 1 - 6, and 9, reserved fo	or other or future use.
Y N	7. Does the patient have perman	nent non-function or disease of the structures that normally permit food to
i Ņ	reach or be absorbed from the	e small bowel?
YN	Does the patient require tube commensurate with the patier	feedings to provide sufficient nutrients to maintain weight and strength nt's overall health status?
A)	10. Print product name(s).	
B)		
	11. Calories per day for each pro-	durt?
· A)	11. Calones per day for each pro-	oder:
B)		
	12. Days per week administered?	? (Enter 1 - 7)
	13. Circle the number for method	
1 2 3 4	1 - Syringe 2 - Gravity	3 - Pump 4 - Does not apply
Y N D	14. Does the patient have a docu	umented allergy or intolerance to semi-synthetic nutrients?
	15. Additional information when	
NAME OF PERSON ANSWER	ING SECTION B QUESTIONS, IF OTI	HER THAN PHYSICIAN (Please Print):
NAME:		TITLE:
PHYSICIAN NAME, ADDRES	S (Printed or Typed)	
THE STOCK STATE APPROPRIES	e transmit is the sail	
		PHYSICIAN'S UPIN:
		PHYSICIAN'S TELEPHONE #: ()

(May be completed by the supplier)

CERTIFICATION TYPE/DATE:

If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked, "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked, "INITIAL," and also indicate the effective date of the order change in the space marked, "REVISED." If this is a recertification (to be completed at intervals required by the DMERC), indicate the initial date needed in the space marked, "INITIAL," and also indicate the recertification date in the space marked, "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:

Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:

Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:

If the place of service is a facility, indicate the name and complete address of the facility.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:

Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

HCPCS CODES, WARRANTY:

List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN. If the item billed is a replacement for a previously purchased item, place a check mark in the blank for that HCPCS code. If the item ordered is covered by a warranty, the length and type of warranty must be indicated. If there is more than one warranty on the item, only the <u>longest</u> warranty <u>Length</u> (months or years) should be indicated that applies to any <u>one</u> of the warranty types on that item. List only the one warranty <u>Type</u> that lasts the longest: (1): Full replacement; (2): Pro-rated replacement; (3): Parts & Labor, (4): Parts Only.

SECTION B:

(May not be completed by the supplier nor anyone in a financial relationship with the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D, Page 2 of this CMN) by the ordering physician.)

EST. LENGTH OF NEED:

Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:

In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:

This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank, if other information is requested.

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(This only appears on certain CMNs.) When it appears, it references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

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PHYSICIAN NAME, ADDRESS:

Indicate physician's name and complete mailing address.

UPIN:

Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:

Effective 10/01/95	DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER	DMERC 10.02B
	Certificate Of Medical Necessity: ENTERAL NUTRITION	PAGE 2 OF 2
PATIENT NAME:	HICN:	
SECTION C	Confirmation Of Physician Order / Narrative Description Of Equipment And Co	et
(1) <u>Narrative</u> diagnos (3) Supplier's charge	ses given by physician; (2) <u>Narrative</u> description of all items, accessories, options and e; and (4) Medicare Fee Schedule Allowance for <u>each</u> item, accessory, option and sup	d supplies ordered;
	(See Instructions On Back)	
		I
•		
I .		
	A Clarecture Date	
SECTION D	Physician Attestation and Signature/Date	to tems ordered
I certify the medical necessity	ritify that I have received Sections A, B, and C of this Certificate Of Medical Necessity (including of these items for this patient. I have reviewed the answers in Section B of this form. Any statement and signed by me. The foregoing information is true, accurate and complete, to the best of my knowled to concealment of material fact may subject me to civil or criminal liability.	
	PHYSICIAN'S SIGNATUREDAT	E/
	(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)	

(To be completed by the supplier)

CONFIRMATION OF PHYSICIAN ORDER/ NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier confirms physician's original order, giving (1) <u>narrative</u> diagnoses given by physician; (2) a <u>narrative</u> description of the item(s) ordered, as well as <u>all</u> options, accessories, supplies and drugs; (3) the supplier's charge for each item, option, accessory, supply and drug; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:

(Physician Attestation and Signature)

PHYSICIAN ATTESTATION:

The physician's signature certifies that (1) the Certificate of Medical Necessity which he/she is reviewing includes two sheets containing Sections A, B, C and D; (2) Section B has not been completed by the supplier nor anyone in a financial relationship with the supplier, and the answers are correct; (3) the diagnoses and prescribed items listed in Section C are

accurate.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies that the items

ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

[FR Doc. 95-24922 Filed 10-5-95; 8:45 am]

BILLING CODE 4120-03-C