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

Effective 10/93 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 10.01**

CERTIFICATE OF MEDICAL NECESSITY: PARENTERAL OR ENTERAL NUTRITION

SECTION A ☐ **INITIAL** ☐ **REVISED** ☐ **RECERTIFICATION**

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

(_ _ _) _ _ _ - _ _ _ _ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(_ _ _) _ _ _ - _ _ _ _ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S) WARRANTY LENGTH TYPE

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SECTION B **CLINICAL INFORMATION**

DIAGNOSIS (ICD9): _____ _____ _____ _____

PT. HT. ____ (IN.) PT. WT. ____ (LBS) DOB ____/____/____

I LAST EXAMINED THIS PATIENT FOR THIS CONDITION ON: _____/_____/_____ PT. SEX ____ (M OR F)

DATE NEEDED INIT ____/____/____ REV/RECERT ____/____/____

EST. LENGTH OF NEED: # OF MONTHS: ___ 1-99 (99 = LIFETIME)

ANSWER QUESTIONS 1-6 FOR PARENTERAL, ANSWER 2, 6-15 FOR ENTERAL Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

[ ] 1. Does the patient have severe permanent disease of the 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?

[ ] 3. Days per week infused? Enter 1-7.

4. Formula components:

Amino acid _____(ml/day) _____ concen % _____ gms protein/day

Dextrose_____ (ml/day) _____ concen %

Lipids _____ ml/day _____ days/week _____ concen %

[ ] 5. What is the route of administration?
1 - Central line
2 - Peripheral line
3 - Hemodialysis access line
7 - Peripherally inserted central catheter (PICC)

[ ] 6. Has there been a break in therapy of two or more consecutive 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?

[ ] 8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status?

[ ] 9. What is the prescribed route of administration?
4 - Nasogastric tube
5 - Gastrostomy tube
6 - Jejunostomy tube

10. Product name? _____

11. Calories per day? _____

[ ] 12. Days per week administered? Enter 1-7.

[ ] 13. Method of administration?
1 - Syringe
2 - Gravity
3 - Pump

[ ] 14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?

15. Additional information when required by policy:

_____

_____

_____

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 reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ __/__/__

PHYSICIAN'S SIGNATURE DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (_ _ _) _ _ _ - _ _ _ _

DB 6.93

SECTION A: (To be completed by the supplier)

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:	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.

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0534

ATTENDING PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY FOR HOME OXYGEN THERAPY *(Legible handwritten entries acceptable)*

Patient's Name, Address, and HIC No.	Supplier's Name, Address, and Identification No.

Certification: ☐ Initial ☐ Revised ☐ Renewed

INFORMATION BELOW TO BE ENTERED ONLY BY PHYSICIAN OR PHYSICIAN'S EMPLOYEE

1. Pertinent Diagnoses, ICD-9-CM Codes, and Findings - CHECK ALL THAT APPLY:

☐ Emphysema (492.8)
☐ COPD (496)
☐ Cor Pulmonale (416.9)
☐ Interstitial Disease (515)
☐ Other _____ (Specify) (Code)
☐ Chronic Obstructive Bronchitis (491.2)
☐ Chronic Obstructive Asthma (493.20)
☐ Congestive Heart Failure (428.0)
☐ Secondary Polycythemia (289.0)
☐ Hematocrit 57% or more Yes☐ No☐

2.A. I last examined this patient for this condition on: ____/____/____ (Month / Day / Year)

2.B. Home oxygen prescribed: ____/____/____ (Month / Day / Year)

2.C. Estimated length of need:
☐1-3 months ☐4-12 months ☐ Lifetime

3.A. Results of Most Recent Arterial Blood Gas and/or Oxygen Saturation Tests (Patient Breathing Room Air)

	PO2	02 Saturation	Date
(1) At Rest			
(2) Walking			
(2) Sleeping			
(3) Exercising			
(4) Other :			

3.C. Physician/Provider Performing Test(s) *(Printed/Typed Name and Address)*:

3.B. If performed under conditions other than room air, explain:

NOTE: If PO2 Level exceeds 59 mm Hg or the arterial blood saturation exceeds 89% at rest on room air, the claim will be disallowed without compelling medical evidence. Check block ☐ if you have attached a separate statement on your letterhead of additional documentation.

4. Oxygen Flow Rate : _____ Liters per minute ☐ Continuous (24 hrs/day)

☐ Noncontinuous (Enter hrs/day): _____ Walking _____Sleeping _____Exercise Program _____Other (specify) _____

5. Oxygen Equipment Prescribed If you have prescribed a particular form of delivery, check applicable block(s). Otherwise leave blank.

A. Supply System

(1) Stationary Source ☐ Concentrator ☐ Liquid Oxygen ☐ Compressed Gas ☐ Other

(2) Portable or Ambulatory Source ☐ Liquid Oxygen ☐ Compressed Gas ☐ Other _____

B. Delivery System

☐ (1) Nasal Cannula
☐ (2) 02 Conserving Device
☐ Pulse 02 System
☐ Reservoir System
☐ Other _____
☐ (3) Transtracheal Catheter
☐ (4) Other _____

6. If you have prescribed a portable or ambulatory system, describe activities/exercise that patient regularly pursues which require this system in the home and which cannot be met by a stationary system (e.g., amount and frequency of ambulation).

CERTIFICATION

THE PATIENT HAS APPROPRIATELY TRIED OTHER TREATMENT MEASURES WITHOUT SUCCESS. OXYGEN THERAPY AND OXYGEN EQUIPMENT AS PRESCRIBED IS MEDICALLY INDICATED AND IS REASONABLE AND NECESSARY FOR THE TREATMENT OF THIS PATIENT. 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 SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Attending Physician's Signature: *(A STAMPED SIGNATURE IS NOT ACCEPTABLE)*	Date:

Physician's Name, Address, Telephone No., and Identification No.:

Effective 10/93 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 09.01**

CERTIFICATE OF MEDICAL NECESSITY: INFUSION PUMPS/HOME GLUCOSE MONITORS

SECTION A **CERTIFICATION:** ☐ **INITIAL** ☐ **REVISED**

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

(___) ___-____ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(___) ___-____ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S)	WARRANTY	LENGTH	TYPE

SECTION B **INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE**

DIAGNOSIS (ICD9): _____ _____ _____ _____

PT. HT. ____ (IN.) PT. WT. ____ (LBS) DOB ____/____/____

I 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 1-8 FOR INFUSION PUMPS, ANSWER 9-13 FOR HOME GLUCOSE MONITORS Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

INFUSION PUMP

___ 1. Which pump has been prescribed?
- 1 - Ambulatory infusion pump
- 2 - Stationary infusion pump
- 3 - Implantable infusion pump
- 4 - Disposable infusion pump (e.g., elastomeric)

2. Provide the HCPCS code for the drug that requires the use of the pump.

_____

3. If a non-specific code was used to answer question 2, provide the name of the drug.

_____

___ 4. What is the route of administration?
- 1 - Intravenous
- 2 - Intra-arterial
- 3 - Epidural
- 4 - Subcutaneous

___ 5. What is the method of administration?
- 1 - Continuous
- 2 - Intermittent
- 3 - Bolus

___ 6. What is the total duration of drug infusion per 24 hours? (Enter number of hours 1 - 24).

[ ] 7. Does the patient have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics?

[ ] 8. Is the patient a cardiac transplant candidate on active status?

HOME GLUCOSE MONITOR

[ ] 9. Does the patient have insulin-treated diabetes?

[ ] 10. Does the patient have documented episodes of
- widely fluctuating blood sugars, and/or
- recurring insulin reactions, and/or
- ketoacidosis?

[ ] 11. Is the patient or caregiver capable of learning proper operation of the device?

[ ] 12. Is the device designed for home rather than clinic use?

___ 13. Approximately how many times per week is the patient expected to check his/her blood sugar? Enter the number of times per week 01 - 99.

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 information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ __/__/__

PHYSICIAN'S SIGNATURE: DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (___) ___-____

08.16/93

SECTION A: (To be completed by the supplier)

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 (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:	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.

Effective 10/93 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 08.01**

CERTIFICATE OF MEDICAL NECESSITY IMMUNOSUPPRESSIVE DRUGS

SECTION A **CERTIFICATION:** ☐ **INITIAL** ☐ **REVISED**

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

(___) ___-____ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(___) ___-____ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S)	WARRANTY	LENGTH	TYPE

SECTION B **CLINICAL INFORMATION**

DIAGNOSIS (ICD9): _____ _____ _____ _____

PT. HT. ____ (IN.) PT. WT. ____ (LBS) DOB ____/____/____

I 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 1-12 FOR IMMUNOSUPPRESSIVE DRUGS Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

What are the drug(s) prescribed and the dosage and frequency of administration of each?

	HCPCS	MG	TIMES PER DAY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

[ ] 4. Has the patient had an organ transplant that was covered by Medicare?

___ 5. Which organ/organs have been transplanted? (Most recent transplant)
___
___

1 - Heart
2 - Liver
3 - Kidney
4 - Bone Marrow
5 - Lung

May enter up to three different organs.

6. On what date was the transplant surgery performed, requiring this therapy?

____/____/____

7. Transplant procedure code (CPT code).

_____

8. Name of facility where transplant was performed.

_____

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?

____/____/____

[ ] 12. Was there a prior transplant failure of this same organ?

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 reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ __/__/__
PHYSICIAN'S SIGNATURE: DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (___) ___-____

6 93

SECTION A: (To be completed by the supplier)

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 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: 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.

Effective 10/93 **DURABLE MEDICAL EQUIPMENT 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.

(_ _ _) _ _ _ - _ _ _ _ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(_ _ _) _ _ _ - _ _ _ _ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S)	WARRANTY	LENGTH	TYPE

SECTION B **INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE**

DIAGNOSIS (ICD9): _____ _____ _____ _____

DOB ____/____/____

I 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 QUESTIONS 6-14 FOR POWER OPERATED VEHICLES (POV)
Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

SEAT LIFT MECHANISM

[ ] 1. Does the patient have severe arthritis of the hip or knee?

[ ] 2. Does the patient have a severe neuromuscular disease?

[ ] 3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?

[ ] 4. Once standing, does the patient have the ability to ambulate?

[ ] 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.

POWER OPERATED VEHICLE

[ ] 6. Would the patient be bed or chair confined without the use of a wheelchair?

[ ] 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?

[ ] 9. Is the patient capable of safely transferring in and out of the POV?

[ ] 10. Is the patient capable of safely operating the controls of the POV?

[ ] 11. Does the patient have adequate trunk stability to be able to safely ride in the POV?

[ ] 12. Are you a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

[ ] 13. Is the patient more than one day's roundtrip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

[ ] 14. Does the patient's condition preclude a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

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 information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ __/__/__
PHYSICIAN'S SIGNATURE: DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (_ _ _) _ _ _ - _ _ _ _

08.16.93

SECTION A: (To be completed by the supplier)

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.
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.

Effective 10/93 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 06.01**

CERTIFICATE OF MEDICAL NECESSITY: TENS

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):	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

SECTION B **INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE**

DIAGNOSIS (ICD9): _____ _____ _____ _____	DOB ___/___/___
I 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 1-6 FOR RENTAL OF TENS, AND 3-12 FOR PURCHASE OF TENS Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

[ ] 1. Does the patient have acute post-operative pain?

2. What is the date of the surgery resulting in acute post-operative pain?
_____/_____/_____

[ ] 3. Does the patient have chronic, intractable pain?

___ 4. How long has the patient had intractable pain?
Enter number of months 1-99.

___ 5. For which, if any, of the following conditions is the TENS unit being prescribed?
1 - Headache
2 - Visceral abdominal pain
3 - Pelvic pain
4 - Temporomandibular joint (TMJ) pain
5 - None of the above

[ ] 6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?

[ ] 7. Has the patient received a TENS trial?

8. What are the dates that trial of TENS unit began and ended?
_____/_____/_____ to _____/_____/_____

9. What is the date that you reevaluated the patient at the end of the trial period?
_____/_____/_____

___ 10. How often has the patient been using the TENS?
1 = Daily
2 = 3 to 6 days per week
3 = 2 or less days per week

[ ] 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 warranted?

___ 12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time:
2 = 2 Leads
4 = 4 Leads

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 information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS	_____ __/__/__ PHYSICIAN'S SIGNATURE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE) ☐ Attending ☐ Consulting ☐ Other ordering UPIN:_____ TELEPHONE #: (___) ___-____

9 9 93

SECTION A: (To be completed by the supplier)

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.
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.

Effective 10/93 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 05.01**

CERTIFICATE OF MEDICAL NECESSITY: SURGICAL DRESSINGS / UROLOGICAL SUPPLIES

SECTION A **CERTIFICATION:** ☐ **INITIAL**

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

(___) ___-____ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(___) ___-____ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

HCPCS CODE(S)

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

SECTION B **CLINICAL INFORMATION**

DIAGNOSIS (ICD9): _____ _____ _____ _____

DOB ___/___/___

I 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 1-3 AND 5-7 FOR SURGICAL DRESSINGS, AND 4-7 FOR UROLOGICAL SUPPLIES
Use Y - Yes, N - No or D for Does Not Apply unless otherwise noted.

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) ____/____/____

UROLOGICAL SUPPLIES

[ ] 4. Does the patient have permanent urinary incontinence?

5. Dressings/Urological Supplies Ordered	6. HCPCS Code	7. Frequency of Change

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 reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ _____ __/__/__

PHYSICIAN'S SIGNATURE: DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (___) ___-____

08 16 93

SECTION A: (To be completed by the supplier)

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 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 EQUIPMENT REGIONAL CARRIER** **DMERC 04.01**

CERTIFICATE OF MEDICAL NECESSITY: ORTHOTICS/LYMPHEDEMA PUMPS/OSTEOGENESIS STIMULATORS/THERAPEUTIC SHOES

SECTION A **CERTIFICATION:** ☐ **INITIAL** ☐ **REVISED**

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

(_ _ _) _ _ _ - _ _ _ _ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(_ _ _) _ _ _ - _ _ _ _ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S)	WARRANTY	LENGTH	TYPE

SECTION B **INFORMATION BELOW TO BE COMPLETED ONLY BY THE 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)

DATE NEEDED INITIAL ____/____/____ REVISED ____/____/____

EST. LENGTH OF NEED: # OF MONTHS: ____ 1-99 (99 = LIFETIME)

ANSWER QUESTIONS 1-6 FOR ANKLE-FOOT AND KNEE-ANKLE-FOOT ORTHOTICS, 7-11 FOR LYMPHEDEMA PUMPS, 12-15 FOR OSTEOGENESIS STIMULATORS, 16 FOR THERAPEUTIC SHOES. Use Y - Yes, N - No, or D for Does Not Apply unless otherwise noted.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOTICS

[ ] 1. Does the patient have weakness or deformity of the foot and ankle which requires stabilization to achieve functional benefit?

[ ] 2. Does the patient have weakness or deformity of the knee which requires stabilization to achieve functional benefit?

[ ] 3. Is the condition expected to exist for more than 6 months?

[ ] 4. Is the patient unable to be fitted with a custom-fitted orthosis?

[ ] 5. Is there a need to control the knee, ankle, or foot in more than one plane?

[ ] 6. Does the patient have a documented neurological, circulatory, or orthopedic status (e.g. a healing fracture lacking normal anatomical integrity or anthropometric proportions) that requires custom fabricating over a model to prevent tissue injury?

LYMPHEDEMA PUMP

[ ] 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?

[ ] 10. Is there postinflammatory lymphatic obstruction?

[ ] 11. Have suitable instructions as to the pressure to be used and the frequency and duration of use been provided?

OSTEOGENESIS STIMULATOR

[ ] 12. Does the patient have a nonunion of a long bone fracture?

[ ] 13. Does the patient have a failed fusion?

[ ] 14. Does the patient have a congenital pseudarthrosis?

___ 15. How many months ago did the patient sustain the long bone fracture being treated or have the fusion that has failed?
(ENTER THE NUMBER OF MONTHS 1 - 99)

THERAPEUTIC SHOES

[ ] 16. Are you the physician who is managing the patient's systemic diabetic condition?

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 (except questions 1-6, which do not require physician completion but do require physician review). The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ __/__/__
PHYSICIAN'S SIGNATURE: DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (_ _ _) _ _ _ - _ _ _ _

08 16.93

SECTION A: (To be completed by the supplier)

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.
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 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:	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.

Effective 10/93 DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER DMERC 03.01

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
(___) ___-____ 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 THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE

DIAGNOSIS (ICD9): _____ _____ _____ _____	DOB ___/___/___
I 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 12-14 FOR CPAP, 18-22 FOR SUCTION PUMP. Use Y - Yes, N - No, or D for Does Not Apply unless otherwise noted.

1. Reserved for future use.
2. Reserved for future use.
3. Reserved for future use.
4. Reserved for future use.
5. Reserved for future use.
6. Reserved for future use.
7. Reserved for future use.
8. Reserved for future use.
9. Reserved for future use.
10. Reserved for future use.
11. Reserved for future use.

CONTINUOUS POSITIVE AIRWAY PRESSURE SYSTEM (CPAP)

___ 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).

[ ] 13. Is surgery a likely alternative to CPAP?

[ ] 14. Does the patient have obstructive sleep apnea?

15. Reserved for future use.
16. Reserved for future use.
17. Reserved for future use.

SUCTION PUMP

[ ] 18. Does the patient have difficulty raising and clearing secretions?

[ ] 19. Does the patient have cancer or surgery of the throat or mouth?

[ ] 20. Does patient have dysfunction of the swallowing muscles?

[ ] 21. Is the patient unconscious or in an obtunded state?

[ ] 22. Does patient have a tracheostomy?

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 information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS	_____ __/__/__ PHYSICIAN'S SIGNATURE: DATE (A STAMPED SIGNATURE IS NOT ACCEPTABLE) ☐ Attending ☐ Consulting ☐ Other ordering UPIN:_____ TELEPHONE #: (___) ___-____

08 '6 93

SECTION A: (To be completed by the supplier)

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.
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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.

Effective 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.

(___) ___-____ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(___) ___-____ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S)	WARRANTY	LENGTH	TYPE

SECTION B **INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE**

DIAGNOSIS (ICD9): _____ _____ _____ _____

PT. HT. ____ (IN.) PT. WT. ____ (LBS) DOB ____/____/____

I 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 1-4 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?

[ ] 2. Is the patient unable to operate a wheelchair manually?

[ ] 3. Is the patient capable of safely operating the controls of a power wheelchair?

[ ] 4. Would the patient be bed or chair confined without the use of a wheelchair?

[ ] 5. Does patient have quadriplegia?

[ ] 6. Does patient have a fixed hip angle?

[ ] 7. Does patient have a trunk cast or brace that requires a reclining back feature for positioning?

[ ] 8. Does the patient have a cast or brace which prevents 90 degree flexion of the knee?

[ ] 9. Does patient have a musculoskeletal condition that prevents 90 degree flexion at the knee?

[ ] 10. Does patient have excessive extensor tone of the trunk muscles?

[ ] 11. Does patient have weak neck muscles requiring support?

[ ] 12. Does patient have weak upper body muscles, upper body insta-bility or muscle spasticity?

[ ] 13. Does patient have use of only one hand/arm and the condition is expected to last for 6 months or more?

[ ] 14. Is there hemiplegia or uncontrolled arm movements?

[ ] 15. Does patient have a need for arm height different than that available using non-adjustable arms?

[ ] 16. Does the patient need to rest in a recumbent position two or more times during the day?

[ ] 17. Is transfer between bed and wheelchair very difficult?

___ 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, use 4) use 1-24.

[ ] 19. Is the patient able to place his/her feet on the ground for propulsion in a standard wheelchair?

[ ] 20. Is the patient able to self-propel in a standard wheelchair?

[ ] 21. Reserved for future use.

[ ] 22. Can/does patient self-propel in a lightweight wheelchair?

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 information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ __/__/__
PHYSICIAN'S SIGNATURE: DATE
(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (___) ___-____

08 16 93

SECTION A: (To be completed by the supplier)

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:	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.

Effective 10/93 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 01.01**

CERTIFICATE OF MEDICAL NECESSITY: HOSPITAL BEDS/SUPPORT SURFACES

SECTION A **CERTIFICATION:** ☐ **INITIAL** ☐ **REVISED**

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NO.

(___) ___-____ HICN_____

SUPPLIER NAME, ADDRESS, TELEPHONE, AND NSC NUMBER

(___) ___-____ NSC _____

PLACE OF SERVICE ____ REPLACEMENT ITEM ____

NAME AND ADDRESS OF FACILITY IF APPLICABLE (SEE BACK OF FORM):

HCPCS CODE(S) WARRANTY LENGTH TYPE

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SECTION B **INFORMATION BELOW TO BE COMPLETED ONLY BY THE PHYSICIAN OR PHYSICIAN'S EMPLOYEE**

DIAGNOSIS (ICD9): _____ _____ _____ _____

DOB ____/____/____

I 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 ALTERNATING 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?

2. Reserved for future use.

[ ] 3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?

[ ] 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?

[ ] 5. Does the patient require traction which can only be attached to a hospital 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?

[ ] 7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

[ ] 8. Reserved for future use.

9. Reserved for future use.

[ ] 10. Reserved for future use.

[ ] 11. Reserved for future use.

[ ] 12. Is the patient highly susceptible to decubitus ulcers?

[ ] 13. Are you supervising the use of the device?

[ ] 14. Does the patient have coexisting pulmonary disease?

[ ] 15. Has a conservative treatment program been tried without success?

[ ] 16. Was a comprehensive assessment performed after failure of conservative treatment?

[ ] 17. Is the home electric system sufficient for the anticipated increase in energy consumption?

[ ] 18. Is structural support adequate to support the air-fluidized bed?

[ ] 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?

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
Stage:	____	____	____
Max Length (cm):	____	____	____
Max Width (cm):	____	____	____

___ 22. Over the past month, the patient's ulcer(s) has/have:

1) improved 2) remained the same 3) worsened

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 information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PHYSICIAN NAME, ADDRESS

_____ _____ __/__/__

PHYSICIAN'S SIGNATURE: DATE

(A STAMPED SIGNATURE IS NOT ACCEPTABLE)

☐ Attending ☐ Consulting ☐ Other ordering

UPIN:_____

TELEPHONE #: (___) ___-____

.8 6 93

SECTION A: (To be completed by the supplier)

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.
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.

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

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 Necessity: HOSPITAL BEDS PAGE 1 OF 2

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (check if applicable) / WARRANTY (see reverse) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 1, AND 3-7 FOR HOSPITAL BEDS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
	QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.
Y N D	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?
Y N D	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
Y N D	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 can only be attached to a hospital bed?
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?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (___)___-____

Rev. 7/25/95

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 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:	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 **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 Cost**

(1) Narrative diagnoses given by physician; (2) Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 Necessity: SUPPORT SURFACES PAGE 1 OF 2

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (check if applicable) / WARRANTY (see reverse) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 12,13 & 21 FOR ALTERNATING PRESSURE PADS OR MATTRESSES; 13-22 FOR AIR 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 RESERVED FOR OTHER OR FUTURE USE.
Y N D	12. Is the patient highly susceptible to decubitus 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 been tried without success?
Y N D	16. Was a comprehensive assessment performed after failure of conservative treatment?
Y N D	19. Are open, moist dressings used for the treatment of the patient?
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?
	21. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.
	Pressure Ulcer / Ulcer # 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) has/have: 1) Improved 2) Remained the same 3) Worsened?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ _____ TITLE: _____ _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (___) ___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** DMERC 01.02B

Certificate Of Medical Necessity: SUPPORT SURFACES PAGE 2 OF 2

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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) narrative diagnoses given by physician; (2) a narrative description of the item(s) ordered, as well as all 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**

Certificate Of Medical Necessity: MOTORIZED WHEELCHAIRS PAGE 1 OF 2

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; HT. _____ (in.) (*optional*); WT. _____ (lbs.); Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (*check if applicable*) / WARRANTY (*see reverse*) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor Anyone In A Financial Relationship With The Supplier.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1-4 FOR MOTORIZED WHEELCHAIR BASE, 4-18 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
		Questions 3, 9, 11 - 14, and 17, reserved for other or future use.
Motorized Whlchr Base	Y N D	1. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	2. Have all types of manual wheelchairs been considered and ruled out?
Motorized Whlchr Base and Accessories	Y N D	4. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	5. Does the patient have quadriplegia?
Reclining Back	Y N D	6. Does the patient have a fixed hip angle?
Reclining Back	Y N D	7. Does the patient have a trunk cast or brace that requires a reclining back feature for positioning?
Elevating Leg Rest	Y N D	8. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating leg rest?
Reclining Back	Y N D	10. Does the patient have excessive extensor tone of the trunk muscles?
Adjustable Height Armrest	Y N D	15. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back	Y N D	16. Does the patient need to rest in a recumbent position two or more times during the day?
Reclining Back; Adjustable HT. Armrest	_____	18. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____
	PHYSICIAN'S TELEPHONE #: (___) ___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 02.02A**

Certificate Of Medical Necessity: MOTORIZED WHEELCHAIRS **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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) narrative diagnoses given by physician; (2) a narrative description of the item(s) ordered, as well as all 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 02.02B**

Certificate Of Medical Necessity: MANUAL WHEELCHAIRS PAGE 1 OF 2

SECTION A **Certification Type/Date:** **INITIAL** __/__/__ **REVISED** __/__/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB __/__/__; HT. _____ (in.) (*optional*); WT. _____ (lbs.); Sex ____ (M/F)

HCPCS CODES	REPLACEMENT (*check if applicable*)	WARRANTY (*see reverse*) Length (months)	WARRANTY Type (1-4)

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor Anyone In A Financial Relationship With The Supplier.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 4 AND 18-22 FOR MANUAL WHEELCHAIR BASE; 4-18 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
		Questions 1 - 3, 9, 11 - 14, 17, 19, and 21 reserved for other or future use.
Manual Whlchr Base And All Accessories	Y N D	4. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	5. Does the patient have quadriplegia?
Reclining Back	Y N D	6. Does the patient have a fixed hip angle?
Reclining Back	Y N D	7. Does the patient have a trunk cast or brace that requires a reclining back feature for positioning?
Elevating Leg Rest	Y N D	8. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating leg rest?
Reclining Back	Y N D	10. Does the patient have excessive extensor tone of the trunk muscles?
Adjustable HT. Armrest	Y N D	15. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back	Y N D	16. Does the patient need to rest in a recumbent position two or more times during the day?
Reclining Back; Adjustable HT. Armrest; Any Type Ltwt. Whlchr	_____	18. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)
Any Type Ltwt. Whlchr	Y N D	20. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
Any Type Ltwt. Whlchr	Y N D	22. If the answer to question #20 is "No", would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #:** (___) ___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 02.02B**

Certificate Of Medical Necessity: MANUAL WHEELCHAIRS **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 03.02**

Certificate Of Medical Necessity: CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) PAGE 1 OF 2

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse)	HCPCS CODES / REPLACEMENT (*check if applicable*) / WARRANTY (*see reverse*) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 12 AND 14 FOR CPAP (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Questions 1 - 11, and 13, reserved for other or future use.
__ __	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) (If greater than 99, enter 99.)
Y N D	14. Does the patient have obstructive sleep apnea?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____
	PHYSICIAN'S TELEPHONE #: (___)___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 03.02**

Certificate Of Medical Necessity: CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative description of all items, accessories, options and supplies ordered; **(3)** Supplier's charge; and **(4)** Medicare Fee Schedule Allowance for each item, accessory, option and supply.

(See Instructions On Back)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 04.02B**

Certificate Of Medical Necessity: LYMPHEDEMA PUMPS PAGE 1 OF 2

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB ___/___/___; Sex ___ (M/F)

HCPCS CODES	REPLACEMENT (check if applicable)	WARRANTY (see reverse) Length (months)	WARRANTY (see reverse) Type (1-4)

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 7-11 FOR LYMPHEDEMA PUMP (Circle Y for Yes, N for No, or D for Does Not Apply)
	QUESTIONS 1 - 6, reserved for other or future use.
Y N D	7. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?
Y N D	8. Has the patient had surgery or radiation that interrupted normal lymphatic drainage or is there a congenital abnormality of lymphatic drainage?
Y N D	9. Is the device prescribed for the treatment of chronic venous insufficiency with edema and/or venous ulcers?
Y N D	10. Is there intractable lymphedema?
Y N D	11. Has the physician prescribed the pressures to be used and the frequency and duration of use of this device?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	PHYSICIAN'S UPIN: _____ PHYSICIAN'S TELEPHONE #: (___)___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 04.02B**

Certificate Of Medical Necessity: LYMPHEDEMA PUMPS **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 04.02C**

Certificate Of Medical Necessity: OSTEOGENESIS STIMULATOR **PAGE 1 OF 2**

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___, Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (*check if applicable*) / WARRANTY (*see reverse*) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 12-15 FOR OSTEOGENESIS STIMULATOR. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	QUESTIONS 1 - 11, and 16, reserved for other 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 pseudoarthrosis?
_____	15. How many months ago did the patient sustain the long-bone fracture being treated or have the fusion that has failed? (Enter number of months 1-99)

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____
	PHYSICIAN'S TELEPHONE #: (___)___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 04.02C**

Certificate Of Medical Necessity: OSTEOGENESIS STIMULATOR **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 06.02**

Certificate Of Medical Necessity: TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) PAGE 1 OF 2

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___ Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (check if applicable) / WARRANTY (see reverse) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 1 - 6 FOR RENTAL OF TENS, AND 3 - 12 FOR PURCHASE OF TENS. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
Y N D	1. Does the patient have acute post-operative pain?
___/___/___	2. What is the date of surgery resulting in acute post-operative pain?
Y N D	3. Does the patient have chronic, intractable pain?
[_____ months]	4. How long has the patient had intractable pain? (Enter number of months, 1 - 99.)
1 2 3 4 5	5. Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above
Y N D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
Y N D	7. Has the patient received a TENS trial?
Began/Ended ___/___/___ ___/___/___	8. What are the dates that trial of TENS unit began and ended?
___/___/___	9. What is the date that you reevaluated the patient at the end of the trial period?
1 2 3	10. How often has the patient been using the TENS? (Circle appropriate number) 1 = Daily 2 = 3 to 6 days per week 3 = 2 or less days per week
Y N D	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 warranted?
2 4	12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time: (Circle appropriate number) 2 = 2 leads 4 = 4 leads

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (___) ___-____

Rev. 7/25/95

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 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, 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 06.02**

Certificate Of Medical Necessity: TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative description of all items, accessories, options and supplies ordered; **(3)** Supplier's charge; and **(4)** Medicare Fee Schedule Allowance for each item, accessory, option and supply.

(See Instructions On Back)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 07.02A**

Certificate Of Medical Necessity: SEAT LIFT MECHANISM PAGE 1 OF 2

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (*check if applicable*) / WARRANTY (*see reverse*) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 1 -5 FOR SEAT LIFT MECHANISM (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
Y N D	1. Does the patient have severe arthritis of the hip or knee?
Y N D	2. Does the patient have a severe neuromuscular disease?
Y N D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
Y N D	4. Once standing, does the patient have the ability to ambulate?
Y N D	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 medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (___)___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 07.02A**

Certificate Of Medical Necessity: SEAT LIFT MECHANISM **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 07.02B**

Certificate Of Medical Necessity: POWER OPERATED VEHICLE (POV) PAGE 1 OF 2

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (*check if applicable*) / WARRANTY (*see reverse*) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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) (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 rheumatology?
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 surgery, neurology, or rheumatology?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (___) ___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 07.02B**

Certificate Of Medical Necessity: POWER OPERATED VEHICLE (POV) **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative 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)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 08.02**

DMERC Information Form: IMMUNOSUPPRESSIVE DRUGS

ALL INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/Date: **INITIAL** __/__/__ **REVISED** __/__/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-_____ HICN _____	(___) ___-_____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB __/__/__; Sex ___ (M/F)

TRANSPLANT DIAGNOSIS CODES (ICD-9) (CIRCLE APPROPRIATE CODES): V42.1 (HEART); V42.7 (LIVER); V42 .0 (KIDNEY); V42.6 (LUNG); V42.8 (BONE MARROW); V42.8 (OTHER-SPECIFY) (_____)

ANSWERS	ANSWER QUESTIONS 1 - 5 AND 8 - 12 FOR IMMUNOSUPPRESSIVE DRUGS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Questions 6 and 7, reserved for other or future use.
	What are the drug(s) prescribed and the dosage and frequency of administration of each? HCPCS MG TIMES PER DAY 1. _____ _____ _____ 2. _____ _____ _____ 3. _____ _____ _____
Y N	4. Has the patient had an organ transplant that was covered by Medicare?
Enter Correct Number(s) ____ ____ ____	5. Which organ(s) have been transplanted? (List most recent transplant) (May enter up to three different organs). 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung
_____	8. Name of facility where transplant was performed.
_____	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?
Y N	12. Was there a prior transplant failure of this same organ?

PHYSICIAN NAME, ADDRESS (Printed or Typed)	_____ SUPPLIER'S SIGNATURE (A Stamped Signature Is Not Acceptable) __/__/__ DATE
UPIN: _____	_____ PRINT NAME
TELEPHONE #: (___) ___-_____	

Rev. 7/25/95

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, 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.
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.

Effective 10/01/95 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 09.02**

Certificate Of Medical Necessity: EXTERNAL INFUSION PUMP PAGE 1 OF 2

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (*check if applicable*) / WARRANTY (*see reverse*) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 1 - 7 FOR EXTERNAL INFUSION PUMP. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
1 3 4	1. Circle number of pump which has been prescribed: 1 - External infusion pump (non-disposable); 2 - Reserved for other or future use; 3 - Implantable infusion pump; 4 - Disposable infusion pump (e.g., elastomeric)
HCPCS CODE: _____	2. Provide the HCPCS code for the drug that requires the use of the pump.
_____	3. If non-specific code was used to answer questions, print name of drug.
1 3 4	4. Circle number for route of administration? 1 - Intravenous; 2 - Reserved for other or future use; 3 - Epidural; 4 - Subcutaneous
1 2 3	5. Circle number for method of administration? 1 - Continuous; 2 - Intermittent; 3 - Bolus
_____	6. What is the total duration of drug infusion per 24 hours? (1 - 24)
Y N D	7. Does the patient have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____
	PHYSICIAN'S TELEPHONE #: (___) ___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 09.02**

Certificate Of Medical Necessity: EXTERNAL INFUSION PUMP **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative description of all items, accessories, options, supplies and drugs ordered; **(3)** Supplier's charge; and **(4)** Medicare Fee Schedule Allowance for each item, accessory, option, supply and drug.

(See Instructions On Back)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 10.02A**

Certificate Of Medical Necessity: PARENTERAL NUTRITION PAGE 1 OF 2

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___) ___-____ HICN _____	(___) ___-____ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB ___/___/___; HT _____ (in.); WT. _____ (lbs.); Sex ___ (M/F)

HCPCS CODES	REPLACEMENT (check if applicable)	WARRANTY (see reverse) Length (months)	WARRANTY (see reverse) Type (1-4)

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 1, AND 3 - 5 FOR PARENTERAL NUTRITION (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Question 2 reserved for other or future use.
Y N	1. Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength 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/day) _____concentration % Lipids _____(ml/day) _____days/week _____concentration %
1 3 7	5. Circle the number for the route of administration. 2, 4, 5, 6 - Reserved for other or future use. 1 - Central Line; 3 - Hemodialysis Access Line; 7 - Peripherally Inserted Catheter (PIC)

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #:** (___) ___-____

Rev. 7/25/95

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 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:	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 **DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER** **DMERC 10.02A**

Certificate Of Medical Necessity: PARENTERAL NUTRITION **PAGE 2 OF 2**

PATIENT NAME: _____ **HICN:** _____

SECTION C **Confirmation Of Physician Order / Narrative Description Of Equipment And Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative description of all items, accessories, options and supplies ordered; **(3)** Supplier's charge; and **(4)** Medicare Fee Schedule Allowance for each item, accessory, option and supply.

(See Instructions On Back)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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 10.02B**

Certificate Of Medical Necessity: ENTERAL NUTRITION PAGE 1 OF 2

SECTION A **Certification Type/Date:** INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(___)___-____ HICN _____	(___)___-____ NSC # _____
PLACE OF SERVICE _____	PT DOB ___/___/___; HT. _____ (in.); WT. _____ (lbs.); Sex ___ (M/F)
NAME and ADDRESS of FACILITY if applicable (see reverse):	HCPCS CODES / REPLACEMENT (check if applicable) / WARRANTY (see reverse) Length (months) / Type (1-4)
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____
	_____ _____ _____ _____

SECTION B **Information Below May Not Be Completed By The Supplier Of The Items/Supplies, Nor 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 7, 8, AND 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 for other or future use.
Y N	7. Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?
Y N	8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status?
A) _____ B) _____	10. Print product name(s).
A) _____ B) _____	11. Calories per day for each product?
_____	12. Days per week administered? (Enter 1 - 7)
1 2 3 4	13. Circle the number for method of administration? 1 - Syringe 2 - Gravity 3 - Pump 4 - Does not apply
Y N D	14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?
	15. Additional information when required by policy:

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: _____ TITLE: _____

PHYSICIAN NAME, ADDRESS (Printed or Typed)	**PHYSICIAN'S UPIN:** _____
	PHYSICIAN'S TELEPHONE #: (___)___-____

Rev. 7/25/95

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.
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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 Cost**

(1) Narrative diagnoses given by physician; **(2)** Narrative description of all items, accessories, options and supplies ordered; **(3)** Supplier's charge; and **(4)** Medicare Fee Schedule Allowance for each item, accessory, option and supply.

(See Instructions On Back)

SECTION D **Physician Attestation and Signature/Date**

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). I 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.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Rev. 7/25/95

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)** narrative diagnoses given by physician; **(2)** a narrative description of the item(s) ordered, as well as all 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.
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[FR Doc. 95–24922 Filed 10–5–95; 8:45 am]
BILLING CODE 4120–03–C