

CERTIFICATE OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT (DME) (EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name (Print)	Last	First	Phone Number ()	License Number
Address		Street	City	State
				ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx (For Rx Renewal, please also complete 2A below)

Patient Name (Print)	Last	First	Phone Number ()	Date of Birth mm / dd / yy	Medi-Cal Number
Address		Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes No Explain "Yes" answer: _____

Equipment required for:

- Less than 10 months (code the TAR for a rental)
- More than 10 months (code the TAR for a purchase)

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

- a) _____
- b) STANDARD: _____ BARIATRIC: _____
- c) Replacing existing equipment? Yes No If yes, explain why: _____
- d) Attach repair estimate if replacement with similar equipment is requested.
- e) Other DME the beneficiary has: _____
- f) How many hours per day of usage? _____
- g) Accessories requested and why: _____
- h) Custom features requested and why: _____
- i) Other equipment currently in the home: Cane Walker Crutches Prosthesis Manual Wheelchair
Power Wheelchair Hospital Bed Oxygen POV (scooter) Other: _____
- j) Patient currently using the following equipment: _____
- k) When/How often: _____
- l) State specific reason for accessories requested: _____

SECTION 4—Diagnosis Information

Diagnoses: _____ Date of onset: _____
Prognosis: _____

SECTION 5—Pertinent History:

SECTION 6—Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____
a) Ambulation: Independent Walker/Cane Assisted Unassisted Unable Bed confined
Recent fall(s) Dizziness/Vertigo Incoordination Ataxia Severe shortness of breath
b) Transfer: Self Self, but with great difficulty Self with a transfer device
Stand by assistant With assistance Mechanical or person lift
c) Pertinent physical findings: Edema (location): _____
Pressure sore(s), state and location: Amputee Cast Ataxia
Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____
Cognitive status: _____ Vision: Impaired Normal
Contractures: _____

SECTION 7—Living Environment:

House/condominium Apartment Stairs Elevator Ramp Hills SNF ICF/DD B&C
Other: _____
Living Assistance: Lives alone With other person(s) Alone most of the day Alone at night
Attendant care: Live in attendant or _____ Hours/day Homemaker Hours _____
Transportation: _____

SECTION 8—Hospital Bed:



Document that this beneficiary requires positioning not feasible in an ordinary bed: _____
Is frequent repositioning required throughout the day? Yes No Explain: _____
Is frequent repositioning required throughout the night? Yes No
Can the beneficiary or caretaker use a "manual" bed? Yes No
If no, explain why: _____

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:


By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print): _____

Name: _____ Title: _____ DME Provider Name: _____
(Please print) (OT, PT, RESNA, etc.) (Please print)
 _____ Date: _____  _____
(Use Ink - A signature stamp is not acceptable) (Use Ink - A signature stamp is not acceptable)

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician's Signature: _____
 _____ Date: _____
(Use Ink - A signature stamp is not acceptable)