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 equiment? 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 dificulty ❒ 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)