

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
DECUBITUS CARE EQUIPMENT (PRESSURE REDUCING SUPPORT SURFACES)

<i>Instructions: The Certificate of Medical Necessity (CMN) must be used for all approved pressure reducing support surfaces under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.</i>											
Name of Consumer					Provider NPI#						
Consumer Medicaid #					Provider Medicaid Legacy # (Optional)						
Consumer Address					City/State/Zip			Date of Birth			
Section A - Must be completed by Prescriber											
Diagnosis(es) with ICD-9 code (Mandatory) and optional description											
<input type="checkbox"/> Yes <input type="checkbox"/> No Skin grafts/flaps? If yes, date of surgery					<input type="checkbox"/> Yes <input type="checkbox"/> No Burns, 3 rd degree? If yes, date If yes, describe burns						
Prescriber order for pressure-reducing support surface. Specify product make/model (Prescription may be attached to this form in lieu of completing this item)											
NOTE: If requesting approval for 30-day coverage post flap/graft surgery, completion of the remainder of section A is NOT REQUIRED.											
Number of requested days			Prescriber ordered wound treatment protocol (Prescription may be attached in lieu of completing this section of the form)								
Date of initial placement of patient on surface											
Note: Date of order(s) must be written within 30 days of prior authorization (PA) submission or placement of consumer on the surface.											
Lab Reports (current within 21 days of PA submission or placement of consumer on surface. May be attached to this form)											
Albumin	Date	Pre-Albumin	Date	Tot. Protein	Date	Hbg.	Date	HCT	Date		
Wound Description— excluding extremities (Current within 21 days prior to PA submission or placement of patient on surface.)											
Date	Location	Appearance	Length	Width	Depth	Stage	Signature-Licensed Individual				
1											
2											
3											
4											
Weight History— For at least 60 days prior to submission of PA request or placement on surface. Wound graph from chart may be submitted in lieu of completing this section of this form.				Date	Wt.	Date	Wt.	Date	Wt.	Date	Wt.
Section B - Prescriber Attestation and Signature/Date											
Prescriber Name (<i>PRINTED</i>)						Prescriber NPI#					
I certify that I am the prescriber identified above. I certify that the information in Section A of this certificate of medical necessity and any information on the attached documents signed and dated by me, are true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.											
Prescriber Signature					Date		Prescriber Medicaid Legacy # (Optional)				