HealthSystems of Mississippi
460 Briarwood Drive
Suite 300
Jackson, MS 39206

HealthSystems of Mississippi Medicaid
Certificate of Medical Necessity Form
For Initial Referral/Orders
Outpatient Physical/Occupational/Speech Therapy

Section A: Beneficiary and Provider Information

Patient Name: _____

Medicaid #: ☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐/☐☐/☐☐☐☐

Age: ☐☐☐ Sex: ☐ (M or F)

Date of last visit: ☐☐/☐☐/☐☐☐☐

Ordering MD/NP/PA Name (First and Last):

_____

Medicaid ID#: ☐☐☐☐☐☐☐☐

Telephone #:

☐☐☐-☐☐☐-☐☐☐☐ Ext.☐☐☐☐

Section B: Clinical Information
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

Diagnoses	ICD-9-CM

Clinical Summary: *Record relative history indicating patient's need for <u>each</u> requested therapy service by discipline, i.e., physical, occupational and/or speech therapy.*

Physician/Nurse Practitioner/Physician Assistant Order(s):

Section C: Physician//Nurse Practitioner/Physician Assistant Attestation, Signature and Date

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the prescribing physician/nurse practitioner/physician assistant identified in Section A and that I have prescribed the orders listed in Section B of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

_____ _____

Signature and Title of Prescribing Provider **Date**