CERTIFICATE OF MEDICAL NECESSITY – ALERT SIGNALER AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the child's caregiver deaf?
Y N D	Does the child have a medical condition that would require specific monitoring with an alarm? If yes, please describe the condition:____

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – AMBU BAG AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ________________________________ Medicaid #: ______________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: _____________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have respiratory failure?
Y N D	Does the beneficiary require manual ventilation on an intermittent basis or hyperventilation?
Y N D	Will the ambu bag be used as a back-up for a mechanically ventilated patient in the case of a power failure?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – ANAL DILATOR AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have any of the following medical conditions? Check all that apply. ☐ Imperforate anus ☐ Anal stricture ☐ Anal sphincter spasms ☐ Post-op anorectal malformations

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – APNEA MONITOR AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Beneficiary Name: ________________________________

Medicaid #: ____________________________________

Date of Birth: _______/_______/_______

Age: _____________ Sex: _____________ (M or F)

HT: __________ (inches) WT: ___________ (lbs)

Date of last visit: _______/_______/_______

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

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Medicaid ID# or MS License #:

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Telephone #: (____)-________-________Ext: ________

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary terminally ill or is there a "do not resuscitate" order in place?
Y N D	Is the beneficiary an infant who has a diagnosis of apnea of prematurity?
Y N D	Is the beneficiary a preterm infant with continued symptomatic apnea past 36 weeks gestational age?
Y N D	Has the beneficiary been observed having or has a recorded episode of prolonged apnea (>20 seconds or bradycardia episodes < 60 bpm for > 5 seconds) within the last three (3) months that is documented by medical personnel and associated with bradycardia, reflux, cyanosis, or pallor?
Y N D	Is the beneficiary an infant who is a sibling of a sudden infant death syndrome (SIDS) child or has two (2) siblings with a diagnosis of apnea?
Y N D	Has the beneficiary had an event/events requiring vigorous stimulation or resuscitation within the past three (3) months?
Y N D	Does the beneficiary have a tracheotomy?
Y N D	Is the beneficiary an infant with brochopulmonary dysplasia who requires oxygen and displays medical instability?
Y N D	Has the beneficiary (adult or child) demonstrated symptomatic apnea due to neurological impairment, craniofacial malfunction or central hyperventilation syndrome or is secondary to gastrointestinal reflux?
Y N D	Does the beneficiary have a condition/diagnosis other than those mentioned above that necessitates the apnea monitor? If yes, attach supporting documentation.
Y N D	Has the beneficiary participated in a three-month trial period of the apnea monitor and was the beneficiary compliant in using the equipment?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – AUGMENTATIVE (ALTERNATIVE) COMMUNICATION DEVICE (ACD) AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Has a team of licensed, qualified professionals evaluated the beneficiary? If yes, identify professions involved below. ☐ Speech-language pathologist ☐ Licensed psychologist with expertise in administering nonverbal test for intelligence ☐ Physical Therapist ☐ Other: (Record Profession) ______________________________ NOTE: A written copy of the evaluation and recommendation must be submitted with the request for approval. (Refer to coverage criteria for specifications).
Y N D	Is the beneficiary's ability to communicate using speech and/or writing insufficient for communication purposes?
Y N D	Is the beneficiary mentally, emotionally, and physically capable of operating/using an ACD?
Y N D	If a request is for rental, has a trial period of at least 30 days, not to exceed 90 days, to ensure that the beneficiary's needs are met by the proposed system and in the most cost-effective manner been conducted? If yes, record dates of trial period:________________________________

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER: ***(Prescription should include specifications for ACD, component accessories, and all necessary therapies and training.)***

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – BATH BENCH/SHOWER CHAIR AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a condition that will not allow him/her to stand alone in a shower and bathe?
Y N D	Is there a shower/bath tub available to the beneficiary?
Y N D	Is the beneficiary able to get into and out of a bath tub/shower (with or without assistance)?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – BATTERY AND BATTERY CHARGER

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	List the equipment for which the battery/battery charger will be used: _______________________________________
___/___/___	Enter date the equipment was originally purchased.
Y N D	Does the beneficiary continue to meet coverage criteria for the equipment requiring batteries as specified in the Policy Manual?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – BILIRUBIN LIGHT, BILI-BLANKET AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ________________________________ Medicaid #: ______________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Has the beneficiary's attending physician diagnosed neonatal jaundice (hyperbilirubinemia)?
Y N D	Is the beneficiary at least two (2) days old but not more than thirty (30) days old?
Y N D	Are the beneficiary's bilirubin levels twelve (12) or greater?
Y N D	Is the treatment limited to five (5) consecutive days and will it occur during the first (30) days of life?
Y N D	Is the beneficiary's bilirubin levels being monitored at the frequency prescribed by the physician?
Y N D	Has the parent or caregiver been trained in the safe and effective use of the home phototherapy equipment?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – BILEVEL POSITIVE AIRWAY PRESSURE (BIPAP) AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: __________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: _________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	Answer the following questions when requesting certification for the initial 3-month trial period or when requesting replacement equipment that is owned by the beneficiary.
Y N D	Is the beneficiary unable to tolerate the necessary Continuous Positive Airway Pressures (CPAP)?
Y N D	Does the beneficiary have frequent central apneas that do not resolve with administration of CPAP?
Y N D	If the beneficiary has chronic lung disease or hypoventilation syndrome, is his/her baseline hypoxemia corrected with administration of CPAP?
Y N D	Does the beneficiary require supplemental humidification?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

CERTIFICATE OF MEDICAL NECESSITY – BLOOD PRESSURE APPARATUS WITH CUFF AND STETHOSCOPE AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a medical condition that his/her physician has specifically ordered at least daily, long-term monitoring of the blood pressure?
Y N D	Is the beneficiary a renal dialysis patient?
Y N D	Is the beneficiary deaf or does he/she have a severe medical condition that prevents him/her from using a manual blood pressure cuff and stethoscope?
Y N D	Has the beneficiary or caregiver demonstrated appropriate use of the equipment and reporting of results?
Y N D	Does the beneficiary have a diagnosis of pregnancy-induced hypertension, pre-eclampsia or eclampsia? *If yes, answer the following question.*
Y N D	Is the beneficiary receiving home health services and/or involved in a high-risk pregnancy program?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – BREAST PROSTHESIS, EXTERNAL

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	Request for external breast prosthesis must include the following documentation: ▪ Beneficiary's past history (including prior prosthetic use, if applicable), and ▪ Beneficiary's current condition and the nature of other medical problems.
Y N D	Does the beneficiary require a bra that aids in, or is essential to, the effectiveness of the prosthesis?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_______________________________________ ____________________

Signature of Physician / Nurse Practitioner / Physician Assistant Date

CERTIFICATE OF MEDICAL NECESSITY – ELECTRIC BREAST PUMP AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the infant (beneficiary) preterm or term and required hospitalization longer than the mother?
Y N D	Does the infant have a diagnosis of cleft palate or cleft lip?
Y N D	Does the infant have a diagnosis of cranial-facial abnormalities?
Y N D	Is the infant unable to suck adequately?
Y N D	Does the infant have a diagnosis of failure to thrive?
Y N D	Does the infant's mother have a diagnosis of breast abscess?
Y N D	Does the infant's mother have a diagnosis of mastitis?
Y N D	Is the infant's mother hospitalized due to illness or surgery on a short-term basis?
Y N D	Has the infant's mother tried a hand pump or has manual expression been tried for two (2) days without success with established milk supply?
Y N D	Has the infant's mother received treatment with short-term medications that may be transmitted to the infant through breast-feeding?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – BUGGY/STROLLER, ADAPTIVE AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have an (alternate) current means of mobility?
Y N D	Is the stroller considered more appropriate than a wheelchair for this beneficiary?
Y N D	Is there an expectation that the beneficiary will need a travel chair or wheelchair within two (2) years?
Y N D	Does the beneficiary need a customized seating system?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician/Nurse Practitioner/Physician Assistant ______________________________ Date __________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – CANE OR CRUTCHES AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ______________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
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Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	Cane:
Y N D	Does the beneficiary have an injury or condition causing impaired ambulation? If yes, specify:______________________________
Y N D	Is there a potential for the beneficiary to ambulate?
Y N D	Is the cane required to relieve stress on a joint postoperatively?
Y N D	Will the cane be used to aid the beneficiary with decreased balance due to vestibular, neurological, or orthopedic conditions?
Y N D	Does the beneficiary require an added base of support provided by the three prong or quad cane?
Y N D	Has the beneficiary achieved increased ambulation skills and no longer require a walker but still need an assistive device with a wider base of support than a straight cane will offer?
ANSWERS	**Crutches:**
Y N D	Are the crutches required to reduce or alleviate weight bearing of the lower extremities due to an injury or surgery?
Y N D	Does the beneficiary need assistance provided by the crutches to progress to ambulation without an assistive device?
ANSWERS	**Forearm Crutches:**
Y N D	Will the beneficiary require long-term crutch use?
Y N D	Does the beneficiary's balance require a base of support as provided by a walker?
Y N D	Does the beneficiary need assistance to increase his/her independence in the community?
Y N D	If attachments are requested, is one or both of the beneficiary's upper extremities compromised?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:
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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician / Nurse Practitioner / Physician Assistant____________________________ Date ______________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – CAR SEAT, SPECIAL NEEDS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: __________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Has a physician determined that a (special needs) car seat is medically necessary and appropriate? If yes, please submit a full description of the beneficiary's postural condition including head and trunk control and height and weight.
Y N D	Does the beneficiary weigh between 20 – 105 pounds?
Y N D	Is the beneficiary's condition of such severity that he/she cannot be safely transported using a standard car seat, car seat belts, or modified vest travel restraints?
Y N D	Is there an expectation of long-term need for the car seat?
Y N D	Will the special needs car seats accommodate at least 36 months of growth?
Y N D	If applicable, will the car seat be equipped with leg extensions to allow for growth over the 36-month period?
Y N D	Will the car seat accommodate the beneficiary's weight/weight gains over the 36-month period?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________________ ____________________

Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – CASCADE HEATER

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary on a ventilator at least 12 hours per 24-hour period?
Y N D	Is the beneficiary able to tolerate cool air pressure support with the use of bi-level equipment?
Y N D	Does the beneficiary have any other condition for which this heated humidifier is necessary? If so, indicate the condition and supply appropriate documentation.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – CHEST PERCUSSOR AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a chronic lung condition such as chronic obstructive pulmonary disease, chronic bronchitis, cystic fibrosis, or emphysema and need manual assistance in mobilizing the respiratory secretions effectively?
Y N D	If manual therapy is appropriate, is there a caregiver available to assist the beneficiary?
Y N D	Have the beneficiary's medical needs been adequately met with all previous means of therapy?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – COLD PAD/PUMP, WATER CIRCULATING AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ________________________________
Medicaid #: ______________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: ___________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ____________________
Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a specific condition/diagnosis for which the application of cold therapy would be therapeutically effective?
Y N D	Is there documentation to justify the medical necessity of a water circulating cold pad/pump instead of items such as ice caps, bags, etc.?
Y N D	Is the water circulating cold pad/pump being used to control body temperature?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

____ ________________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – COMMODE CHAIRS, OTHER TOILETING AIDS AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 *(99 = Lifetime)*

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	Commode Chair:
Y N D	Based on the beneficiary's physical condition, is he/she able to use regular toilet facilities?
Y N D	Does the beneficiary require a chair with detachable arms to facilitate transferring?
Y N D	Is the beneficiary's body configuration such that a chair with detachable arms is required to provide extra commode width?
ANSWERS	**Heavy Duty/Extra Wide Commode Chair:**
WT:_____	What is the beneficiary's current weight?
ANSWERS	**Raised Toilet Seat:**
Y N D	Does the beneficiary have a medical condition which prevents him/her from using a regular commode without a raised seat?
Y N D	Does the beneficiary have a bedside commode which can fit over the toilet?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY - COMPRESSOR

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ______________________________
Date of Birth: ___/___/___ Age:_____ Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
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Medicaid ID# or MS License #: ____________________
Telephone #: (___) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ **1 – 99** ***(99 = Lifetime)***

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	
Y N D	Will the compressor be used in conjunction with a ventilator, nebulizer, or other types of humidification equipment that is not self contained or cylinder driven?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________________ ____________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – COVERED CRIBS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the child/adolescent have a physical condition or behavior problem that warrants the use of the covered crib for the safety of the child during sleeping hours?
Y N D	Does the environment of the home support the size and weight of the crib?
Y N D	Has the child and caregiver tried behavior modification techniques with a qualified therapist?
Y N D	Is there documentation from the therapist and/or physician to support the need of the caged crib?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – COMPLIANCE OF BILEVEL POSITIVE AIRWAY PRESSURE (BIPAP) AND CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE (CPAP)

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ______________________________
Medicaid #: ______________________________
Date of Birth: ___/___/___ Age:_____ Sex: ____ (M or F)
HT: _________ (inches) WT: __________ (lbs)
Date of last visit: ________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: __________________
Telephone #: (___) ______-________ Ext. ________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

CIRCLE Y FOR YES N FOR NO

ANSWERS	BIPAP/CPAP (Answer the following questions after the beneficiary has completed a three-month trial period)
Y N	Has the beneficiary participated in a three-month period that demonstrated the effectiveness of the BIPAP/CPAP treatment?
Y N	Was the beneficiary compliant in using the equipment during the three-month trial period?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________ ______________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE (CPAP) AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Beneficiary Name: ___________________________________
Medicaid #: ____
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: ___________ (inches) WT: ___________ (lbs)
Date of last visit: ____________________________

Ordering MD/NP/PA Name (First and Last):
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Medicaid ID# or MS License #: ___________________
Telephone #: (_____) ______-_________ Ext. _______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): _______1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary an adult whose polysomnogram demonstrates a minimum recording time of six (6) – seven (7) hours with an average of five (5) or more respiratory events (apneas and/or hypopneas) per hour, each lasting a minimum of 10 seconds or more?
Y N D	Is the beneficiary a prepubescent child and the polysomnogram demonstrates an average of one (1) or more respiratory events per hour?
Y N D	Is the beneficiary a child who has documented measurements of increased end-tidal CO2 values that confirm the presence of obstructive sleep apnea?
Y N D	Does the beneficiary have a diagnosis of upper airway resistance syndrome with the presence of at least ten (10) respiratory related EEG arousals per hour of sleep accompanied by a history clinically significant daytime sleepiness (or documented excessive daytime sleepiness as determined by a Multiple Sleep Latency Test), with a significant reduction in EEG arousals following administration of CPAP?
Y N D	Does the beneficiary have any of the following medical conditions? Check all that apply. ☐ Persistent hypoxemia (SaO2 < 90%) during sleep even in the absence of obstructive sleep apnea ☐ Central Sleep Apnea ☐ Chronic alveolar hyperventilation syndrome ☐ Intrinsic lung disease ☐ Neuromuscular disease
Y N D	Has the beneficiary participated in a three-month trial period that demonstrated the effectiveness of the CPAP treatment and that the beneficiary was compliant in using the equipment? **If a request is submitted, the physician must submit a signed certifying statement indicating success of the trial period and patient compliance.**

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____________________________________ _______________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – CRANIAL MOLDING HELMET

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have progressive asymmetry?
Y N D	Has the beneficiary improved with consistent and documented conservative treatment over three (3) months?
Y N D	Is there documented evidence of the caregiver being informed that although “back to sleep” is the recommended sleeping position for infants, the baby needs “tummy time” during periods of wakefulness and observation?
Y N D	Is there documented evidence of the caregiver being taught techniques to change the position of the baby’s head, encourage head turning and neck stretching exercises for torticollis?
Y N D	Does the beneficiary have a diagnosis of positional (deformational) plagiocephaly, which has been confirmed by a pediatric neurosurgeon or pediatric craniofacial surgeon?
Y N D	Has a diagnosis of craniosynostosis been eliminated by a pediatric neurosurgeon prior to the consideration of molding for a helmet?
Y N D	Will the cranial molding helmet be used for the postoperative care of a patient with craniostosis?
Y N D	Has the beneficiary/caregiver received sufficient training in the appropriate application, removal, cleaning and maintenance of the equipment?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY
CUSTOM WEDGE SEAT INSERT

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ________________________________ Medicaid #: ______________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a stable seating device or a mobility device, such as a stroller or wheelchair?
Y N D	Does the beneficiary have posterior pelvic tilt?
Y N D	Does the beneficiary require assistance with proper positioning for stable seating?
Y N D	Does the beneficiary have a wheelchair custom seating system or a custom wheelchair seat?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – DIAPERS

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have an underlying medical condition that prevents control of the bowels or bladder?
Y N D	Are there extenuating circumstances, in which the beneficiary requires more than six (6) diapers per day? If so, provide full documentation that justifies the medical necessity.
Y N D	Is certification being requested for a twelve (12) month timespan? If so, provide full documentation justifying the need for the diapers for the beneficiary whose medical condition is not expected to improve.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – ELECTRONIC SALIVARY REFLEX STIMULATOR

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary experiencing dry mouth caused by Sjogren's Syndrome?
Y N D	Is the beneficiary experiencing dry mouth caused by drug therapy?
Y N D	Is the beneficiary experiencing chronic dry mouth as a result of other known cause(s)? If yes, list the cause(s) below: ____
Y N D	Is the beneficiary experiencing dry mouth from an unknown cause(s)?
Y N D	Does the beneficiary have a cardiac pacemaker or an electronic device above the clavicle?
Y N D	Does the beneficiary have a primary salivary gland malignancy or have clinical evidence of uncontrolled malignancy?
Y N D	Is the beneficiary pregnant?
Y N D	Has the beneficiary undergone screening by a physician, dentist, physician assistant, or nurse practitioner for response to electrostimulation? If yes, record date of screening:_______________________________

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – EMG / BIOFEEDBACK DEVICE

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary in a prescribed therapeutic exercise program?
Y N D	Is the beneficiary experiencing musculoskeletal pain?
Y N D	Does the beneficiary have musculoskeletal stress related injuries?
Y N D	Is the beneficiary on a pre-chronic pain and headache program?
Y N D	Is recertification now being requested after a three (3) month rental period? If so, please provide documentation which demonstrates that desired outcomes are being achieved.
Y N D	Is there documented evidence demonstrating that the beneficiary is capable of using and understanding the mechanism of biofeedback?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – ENTERAL / PARENTERAL / EXTERNAL INFUSION PUMPS OR IV POLES AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Enteral Pump for Enteral Nutrition:**
Y N D	Is the beneficiary tube fed?
Y N D	Are enteral feedings the beneficiary's sole source of nutrition?
ANSWERS	**Parenteral Pump for Parenteral Nutrition:**
Y N D	Is the beneficiary able to absorb nutrients through the gastrointestinal tract?
ANSWERS	**Infusion Pumps:**
Y N D	Is administration of parenteral medication in the beneficiary's home reasonable and medically necessary?
Y N D	Is an infusion pump necessary to safely administer the medication?
ANSWERS	**IV Poles:**
Y N D	Is the beneficiary receiving enteral or parenteral fluids or IV medications in the home setting?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – GAIT TRAINER AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD Name (First and Last):
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Medicaid ID# or MS License #: ____________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the gait trainer being ordered by a **physician** who specializes in physical medicine, orthopedics, or neurology?
Y N D	Does the beneficiary have a condition which causes an unsteady gait and difficulty with ambulation?
Y N D	Has the beneficiary been evaluated by a physical or occupational therapist who is not employed by the DME supplier? If so, submit a copy of the report which documents the medical necessity and indicates the estimated length of need.
Y N D	Is the beneficiary's functional level such that he/she is trainable in the use of a gait trainer?
Y N D	Does the beneficiary have the potential to be ambulatory?
Y N D	Is the beneficiary involved in therapy to regain or strengthen his/her ambulatory function?
Y N D	Is there enough space in the beneficiary's home for the beneficiary to utilize a gait trainer?
Y N D	Are there any medical contraindications to the use of the gait trainer?

PHYSICIAN ORDER:
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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_______________________________________ ________________
Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – GENERIC [For use only when a specific form is unavailable]

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B — CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

CLINICAL SUMMARY: Record information indicating the medical necessity of the requested equipment or supplies. Attach any additional information pertinent to the necessity of the requested equipment according to DOM Medical Review Policy.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

CERTIFICATE OF MEDICAL NECESSITY - GLUCOSE MONITOR AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a diagnosis of insulin dependent or insulin requiring diabetes?
Y N D	Is the beneficiary a non-insulin dependent diabetic? *If **yes**, circle all the items that apply:* a) on diet control, b) on an oral hypoglycemic, c) has a documented history of blood sugars fluctuating outside the normal range?
Y N D	Does the beneficiary have a diagnosis of gestational diabetes requiring treatment?
Y N D	Has the beneficiary or caregiver demonstrated the ability to accurately perform the blood glucose testing and accurately report the results?

1, 2, 3, 4, 5, 6 How often is the beneficiary required to check blood sugar levels per day? If more than six (6): _____.

1, 2, 3, 4, 5, 6 If insulin injections are required, how often does the beneficiary injects insulin per day? If more than six (6): _____

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – HEAT LAMP/HEAT APPLIANCES AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a specific condition/diagnosis for which the application of heat therapy is required for proper healing?
Y N D	Does the beneficiary have a specific condition/diagnosis for which a standard electric heating pad would be therapeutically effective?
Y N D	Does the beneficiary have a medical condition in which the application of a heat lamp will be therapeutically effective?
Y N D	Does the beneficiary have a specific condition/diagnosis for which the application of a water-circulating heat pad/pump will be therapeutically effective?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – HIP ABDUCTOR PILLOW/WEDGE

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a diagnosis, which has resulted in a condition that requires maintaining the beneficiary's hips and thighs in abduction?
Y N D	Does the beneficiary have subluxing or dislocating hip (s)?
Y N D	Does the beneficiary have a diagnosis of an unstable hip?
Y N D	Has the beneficiary had a reduction of a dislocated hip?
Y N D	Has the beneficiary had hip replacement surgery (hemi or total)?
Y N D	Has the beneficiary had hip arthroplasty or hip fracture surgery?
Y N D	Has the beneficiary had an adductor tenotomy or abductor advancement surgery?
Y N D	Is the beneficiary a wheelchair patient who must maintain a degree of hip abduction?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – HOSPITAL BED (FIXED OR VARIABLE HEIGHT) WITH SIDE RAILS AND MATTRESS

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ____________________
Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 *(99 = Lifetime)*

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	
Y N D	Does the beneficiary require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain?
Y N D	Does the beneficiary 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 problems with aspiration?
Y N D	Has the use of pillows or wedges been tried and failed to achieve the desired clinical outcome?
Y N D	Does the beneficiary require traction equipment that can only be attached to a hospital bed?
Y N D	Is the beneficiary semi-comatose or comatose?
Y N D	If a variable height bed is requested, does the beneficiary require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?
Y N D	Does the beneficiary require a heavy duty and/or extra wide bed due to morbid obesity? If yes, please provide the beneficiary's current weight: ________________.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_______________________________________ __________________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SEMI – ELECTRIC HOSPITAL BED WITH SIDE RAILS AND MATTRESS

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 *(99 = Lifetime)*

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	
Y N D	Is the beneficiary capable of operating the controls of the bed?
Y N D	Does the beneficiary live alone with no caregiver available?
Y N D	Does the beneficiary require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain?
Y N D	Does the beneficiary 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 problems with aspiration?
Y N D	Has the use of pillows or wedges been tried and failed to achieve the desired clinical outcome?
Y N D	Does the beneficiary require traction equipment that can only be attached to a hospital bed?
Y N D	Does the beneficiary require a heavy duty and/or extra wide bed due to morbid obesity? If yes, please provide the beneficiary's current weight: ________________.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – HUMIDIFIERS AND HUMIDIFICATION DEVICES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): _______1 – 99 *(99 = Lifetime)*

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	Room Humidifier/Vaporizer:
Y N D	Does the beneficiary have a chronic respiratory condition (diagnosis) in which ease of breathing could be facilitated by increasing moisture content of the air? If yes, indicate the beneficiary's chronic diagnosis by checking all that apply: ☐ Chronic Bronchitis ☐ Chronic Asthma ☐ Chronic Airway Obstruction ☐ Asthmatic Bronchitis ☐ Bronchopulmonary Dysplasia (BPD) ☐ Other *(Please specify)* ______________________________
Y N D	Will the humidifier be used in conjunction with oxygen, or IPPB treatments?
Y N D	Is the beneficiary or caregiver able to effectively use and care for the equipment?
Y N D	Does the beneficiary have an acute upper respiratory infection or chronic cough or cold unrelated to another diagnosis?
ANSWERS	**Heat and Moisture Exchanger (HME):**
Y N D	Does the beneficiary have an existing tracheostomy?
Y N D	Does the beneficiary require supplemental, direct humidification to the tracheostomy?
ANSWERS	**High-Flow or Water Reservoir Humidifier:**
Y N D	Does the beneficiary have an artificial airway and require supplemental, direct humidification to the tracheostomy?
Y N D	Does the beneficiary require supplemental humidification to be used in conjunction with a BiPAP or CPAP?
Y N D	Does the beneficiary require supplemental humidification to be used in conjunction with a ventilator?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – HUMIDIFIER OR ROOM PURIFIER

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B — CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): _______1 – 99 *(99 = Lifetime)*

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	Humidifier:
Y N D	Does the beneficiary have a chronic respiratory condition (diagnosis) in which ease of breathing could be facilitated by increasing moisture content of the air? If yes, indicate the beneficiary's chronic diagnosis by checking all that apply: ☐ Chronic Bronchitis ☐ Chronic Asthma ☐ Chronic Airway Obstruction ☐ Asthmatic Bronchitis ☐ Bronchopulmonary Dysplasia (BPD) ☐ Other *(Please specify)* ______________________________
Y N D	Will the humidifier be used in conjunction with oxygen, or IPPB treatments?
Y N D	Is the beneficiary or caregiver able to effectively use and care for the equipment?
ANSWERS	**Room Purifier:**
Y N D	Does the beneficiary have severe asthma?
Y N D	Does the beneficiary have severe respiratory disease such as recurrent bronchospasm?
Y N D	Does the beneficiary have other chronic severe lower respiratory conditions for which this equipment might be applicable?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant — Date

CERTIFICATE OF MEDICAL NECESSITY – HYDRAULIC LIFT WITH SEAT OR SLING AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary's condition such that periodic position adjustment is necessary to effect improvement or to arrest or retard deterioration in his/her condition?
Y N D	Is the beneficiary bed or chair confined?
Y N D	Is a caregiver available in the home and trained in safe operation of the hydraulic lift?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQ·Health solutions 460 Briarwood Dr. Suite 300 Jackson, MS 39206	Durable Medical Equipment Plan of Care Form

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Beneficiary Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____ Sex: ____ (M or F)	DME Provider: ______________________________ Address: ______________________________ ______________________________ ______________________________
Medicaid Provider #:______________________________ Requester/Contact: ______________________________ Telephone #:________________________Ext._________ Fax #: ______________________________	Ordering MD/NP/PA Name (First and Last): ______________________________ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-___________ Ext. _______

Retrospective Review? ☐ Yes ☐ No If Yes, enter date Medicaid eligibility became effective:_________________

SECTION B REQUESTED SERVICES FOR CONTINUOUS GLUCOSE MONITORING

	Service Description	Service Code CPT	Dates of Need From	Dates of Need Thru	QTY (#)
1					
2					
3					
4					
5					
6					

SECTION C PROVIDER ATTESTATION, SIGNATURE AND DATE

I certify that those items listed in Section B of this form are those exact items ordered and certified as medically necessary by the ordering physician/nurse practitioner/physician assistant specified in Section A of this form, and that these exact items listed in Section B of this form will be delivered to the beneficiary specified in Section A of this form. A DME provider who knowingly or willingly makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may be automatically disqualify the provider as a provider of Medicaid services.

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Signature of DME Provider Date

MISSISSIPPI MEDICAID DISCLAIMER STATEMENT

eQHealth Solutions' certification determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – INCONTINENT PADS / BLUE PADS / UNDERPADS

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: _______________________________ Medicaid #: _____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have an underlying medical condition that prevents control of the bowels or bladder?
Y N D	Are there extenuating circumstances, in which the beneficiary requires more than six (6) incontinent pads per day? If so, provide full documentation that justifies the medical necessity.
Y N D	Is certification being requested for a twelve (12) month timespan? If so, provide full documentation justifying the need for the incontinent pads for beneficiaries whose medical condition is not expected to improve.

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – INSULIN PUMPS

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have insulin dependent diabetes where control has been difficult to achieve?
Y N D	Does the beneficiary have fluctuating blood sugars and is on three (3) or more insulin injections per 24 hours?
Y N D	Does the beneficiary have and is receiving treatment for secondary diabetic complications that require closer blood glucose control?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – INTERMITTENT POSITIVE BREATHING MACHINE AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have difficulty in raising respiratory secretions and has had documented, unsuccessful trials of simpler and more cost-effective methods of secretion mobilization, aerosol deposition, and lung expansion?
Y N D	Does the beneficiary have reduced vital capacity (VC) with ineffective deep breathing and coughing?
Y N D	Is the beneficiary at risk for respiratory failure because of decreased respiratory function secondary to Kyphoscoliosis or neuromuscular disorders?
Y N D	Does the beneficiary have severe brochospasm or exacerbated chronic obstructive pulmonary disease (COPD) and has failed to respond to standard therapy?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – JAW MOTION REHABILITATION SYSTEM

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________	Ordering MD Name (First and Last):
Medicaid #: ____________________________________	____
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)	Medicaid ID# or MS License #: ___________________
HT: __________ (inches) WT: ___________ (lbs)	Telephone #: (____) ______-________ Ext. ______
Date of last visit: __________________________	

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a chronic condition that results in severely limited mandibular motion?
Y N D	Does the beneficiary have hypomobility resulting from trauma, surgery or radiation?
Y N D	Does the beneficiary have compromised biting, chewing, swallowing, speech and oral hygiene?
Y N D	Does the beneficiary have rehabilitation potential to increase the oral orifice adequately, develop strength and improve coordination?
Y N D	Does the beneficiary have TMJ Syndrome?
Y N D	Does the beneficiary have other condition(s) that necessitates a Jaw Motion Rehabilitation System? If yes, record the condition(s):____

PHYSICIAN ORDER:

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – NEBULIZERS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	**ICD-10-CM**

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	**CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY**
Y N D	Has the physician considered use of a metered does inhaler with and without a reservoir or spacer device (if age appropriate) and has determined that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs?
Y N D	Does the beneficiary have an acute condition, such as pneumonia, acute bronchitis, etc., that is expected to resolve in a short time?
Y N D	Does the beneficiary have a chronic condition that is not expected to resolve in a short time or is expected to recur frequently? If yes, check all that apply: ☐ Chronic Bronchitis ☐ Asthma ☐ Congenital Heart Anomaly ☐ Cystic ☐ Diaphragmatic Hernia ☐ Respiratory Distress Syndrome ☐ Chronic Obstructive Pulmonary Disease ☐ Bronchopulmonary Dysplasia
Y N D	Does the beneficiary have a chronic condition other than those listed above that necessitates the use of a nebulizer? If yes, record: ______________________________

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – NEUROMUSCULAR ELECTRICAL STIMULATOR (NMES) AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a documented diagnosis of disuse atrophy and the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves?
Y N D	Does the beneficiary have or has had casting and splinting of a limb?
Y N D	Has the beneficiary had hip replacement surgery?
Y N D	Does the beneficiary have a contracture(s) due to scarring of soft tissue, as in burn lesions?
Y N D	Does the beneficiary require relaxation of muscle spasms?
Y N D	Does the beneficiary require prevention or retardation of disuse atrophy?
Y N D	Does the beneficiary require re-education of muscle?
Y N D	Does the beneficiary require increasing local blood circulation?
Y N D	Does the beneficiary require maintenance or increasing of range of motion?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

CERTIFICATE OF MEDICAL NECESSITY – ORTHOTIC DEVICES OR ORTHOPEDIC FOOTWEAR

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ____________________ Medicaid #: ____________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ______________________	Ordering MD Name (First and Last): ____________________ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Orthotic Positioning Devices:**
Y N D	Does the beneficiary require an orthotic device for the following purposes? *(Check all that apply.)* ☐ Positioning of a body part to prevent further deformities ☐ To increase range of motion in lieu of surgery ☐ To maintain post-surgical improvement (to prevent loss of motion gained through surgery)
ANSWERS	**Orthopedic Footwear:**
Y N D	Is the requested footwear an integral part of a covered leg brace and medically necessary for the proper functioning of the brace?
Y N D	Does the beneficiary's medical condition justify the medical necessity for the braces and/or shoes?
Y N D	Does the beneficiary have a leg length discrepancy?
Y N D	Does the beneficiary have clubfoot?

PHYSICIAN ORDER: ***(Orthotics must be ordered by a physician who by special training in orthopedics, physiatry, or development pediatrics has acquired expertise to ensure that the ordered equipment is appropriate and properly fitted).***

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________________ ____________________

Signature of Physician Date

CERTIFICATE OF MEDICAL NECESSITY – OSTEOGENESIS STIMULATOR (BONE GROWTH STIMULATOR) NON-INVASIVE

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B — CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the ordering physician specialize in orthopedics?
Y N D	Does the beneficiary have a diagnosis of non-union of a traumatic fracture that is at least six (6) months old (from date of injury)?
Y N D	Has the fracture site demonstrated progressive signs of healing for a minimum of (3) months within the six (6) months from the date of injury?
Y N D	Is there radiological documentation that the recipient has attained skeletal maturity?
Y N D	Is the fracture gap more than one-half of the diameter of the bone to be treated?
Y N D	Does the fracture involve a vertebra or flat bone?
Y N D	Does the beneficiary have a demand type pacemaker in proximity to the treatment site?
Y N D	Will the beneficiary be evaluated on a monthly basis to assess progress with use of the stimulator?

PHYSICIAN ORDER:

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – OVERBED CRADLE AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a severe burn or other wound that might have delayed healing from the pressure of bedclothes?
Y N D	Does the beneficiary have an unstable fracture and could pressure from the bedclothes cause pain or interfere with positioning or healing?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – OVERBED TABLE

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	Overbed Table:
Y N D	Does the beneficiary have a medical condition(s) that necessitates the use of an Overbed Table? If yes, the physician must include documentation of all medical conditions that would be improved with the use of the Overbed Table and expected outcomes.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_______________________________________ ________________

Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – OXYGEN AND OXYGEN RELATED EQUIPMENT/SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________

Medicaid #: ____________________________________

Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)

HT: __________ (inches) WT: ___________ (lbs)

Date of last visit: __________________________

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

____

Medicaid ID# or MS License #: ___________________

Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY **Stationary Oxygen Equipment:**
Y N D	Does the beneficiary have a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy?
Y N D	Have alternative treatment methods been tried or considered and deemed clinically ineffective?
(a) ______ (b) ______ (c) ___/___/___	Enter the most recent O2 saturation (should be obtained within 30 days prior to review submission): (a) arterial blood gas pO2 and/or (b) oxygen saturation test (c) date of test
Y N D	Was the O2 saturation level obtained on room air? If not, why?____
Y N D	During sleep, has the beneficiary's O2 saturation fallen >5% by oximetery; or the pO2 fallen 10mm Hg by ABG?
Y N D	Has a Pulmonologist or Thoracic Surgeon concurred with the need for home oxygen therapy for beneficiaries whose arterial pO2 is between 56 and 59mm Hg (O2 saturation of 89%) without signs or symptoms of congestive heart failure, pulmonary hypertension or cor pulmonale?
Y N D	Does the beneficiary have dependent edema caused by congestive heart failure?
Y N D	Has the diagnosis of pulmonary hypertension or cor pulmonale been confirmed by any combination of gated blood pool scan, ECHO cardiogram, or "P" pulmonale on ECG (P wave >3 mm in standard leads II, III, or AVF)?
Y N D	Does the beneficiary have a hematocrit greater than 52% and erythrocytosis?
ANSWERS	**Portable Oxygen Equipment:**
Y N D	Does the beneficiary require continuous oxygen? If Yes:
Y N D	Does the beneficiary require portable O2 while en route to physician's office, hospital, etc.?
Y N D	Is the beneficiary on a prescribed exercise program requiring absences from the stationary equipment?
Y N D	Does the beneficiary require portable oxygen equipment for activities that cannot be accomplished with the use of stationary oxygen equipment?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PACEMAKER MONITOR

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a pacemaker implanted for a cardiac arrhythmia?
Y N D	Is the beneficiary/caregiver capable of performing the pacemaker monitoring function?
Y N D	Does the beneficiary have access to a telephone for transmission?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PEAK FLOW METERS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a medical condition that requires frequent monitoring for ventilatory needs?
Y N D	Does the beneficiary have a medical condition that requires detection of subtle changes in lung function that would require modifications in the treatment plan?
_________ L/sec _________ %	What was the beneficiary's most recent PEFR?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PNEUMATIC COMPRESSOR/LYMPHEDEMA PUMP AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient information	Ordering provider information
Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have refractory lymphedema involving one or more limbs? If yes, please identify the cause of lymphedema: ____
Y N D	Is the lymphedema caused by scarring of the lymphatic channels? If yes, please answer the following:
Y N D	(a) Is there significant ulceration of the lower extremity(ies), and
Y N D	(b) Has the beneficiary received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent, and
Y N D	(c) Has the ulcer(s) failed to heal after six (6) months of continuous treatment?
Y N D	Does the beneficiary have a venous stasis ulcer? *If yes, the following information must be included:* (a) location and size of ulcer(s) ______________________________ (b) length of time each ulcer has been continuously present ______________________ (c) length of treatment with regular compression bandaging ______________________ (d) treatment initiated in the last six (6) months and results______________________ (e) length of treatment with custom fabricated gradient pressure stockings/sleeves____________ (f) routine physician visits for follow-up treatment during the last 6 months____________

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician / Nurse Practitioner / Physician Assistant Date __________________________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY
COMBINATION POSITIVE EXPIRATORY PRESSURE DEVICE, AIRWAY OSCILLATION DEVICE, AND INTERMITTENT FLOW ACCELERATION DEVICE

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have one of the following chronic lung conditions, where mobilization of respiratory secretions is hindered? If yes, check all that apply. ☐ Cystic Fibrosis ☐ Bronchiectasis ☐ Atelectasis ☐ Chronic Bronchitis/COPD ☐ Other disease process in which secretion mobilization is needed *(Please specify)* __________________________
Y N D	Does the beneficiary own a separate device, which could be used to reach the same goals? If so, please specify: ____
Y N D	Has the beneficiary and/or caregiver been taught to use and properly clean the device?
Y N D	If the beneficiary is less than six (6) years of age, is the child able to use the device correctly?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – POSTURAL DRAINAGE BOARD AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. _________

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a chronic lung condition such as chronic obstructive pulmonary disease, chronic bronchitis, cystic fibrosis, or emphysema and needs manual assistance in mobilizing the respiratory secretions effectively?
Y N D	Have the beneficiary's medical needs been adequately met with all previous means of therapy?
Y N D	Is the beneficiary capable of using the board independently?
Y N D	Does the beneficiary have a caregiver who is able to assist in the manual therapy?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – POWER OPERATED VEHICLE

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B — CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary non-ambulatory in the home?
Y N D	Will the power vehicle be used primarily for leisure or recreational activities?
Y N D	Is the beneficiary unable to operate a manual wheelchair?
Y N D	Is the beneficiary capable of safely operating the controls for the power operated vehicle (POV)?
Y N D	Can the beneficiary safely transfer (with or without assistance) into and out of the POV and has adequate trunk stability to be able to sit safely in the POV?

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician/Nurse Practitioner/Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PRESSURE REDUCING SUPPORT SURFACES (AIR FLUIDIZED BED) AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: _____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 ***(99 = Lifetime)***

ANSWERS	Complete the following questions: Circle Y (Yes) - N (No) – or D (Does Not Apply)
	Air Fluidized Bed:
Y N D	In the absence of an air-fluidized bed, would the beneficiary require admission to the hospital for acute care?
Y N D	Does the beneficiary have a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer?
Y N D	Is the beneficiary bedridden as a result of severely limited mobility?
Y N D	Has conservative treatment been tried without success? **If yes, please attach documentation of unsuccessful treatments provided.**
Y N D	Does the beneficiary's home fully accommodate the weight, size, and electrical requirements of the bed?
Y N D	Is the beneficiary receiving skilled nursing services, either through a home health agency or a nurse provided by the supplier who has been trained in wound care?
Y N D	Has the beneficiary/caregiver been fully trained and demonstrated an understanding of the operations and care of the bed?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PRESSURE REDUCING SUPPORT SURFACES (PRESSURE PAD OR POWER PRESSURE REDUCING MATTRESS) AND RELATED SUPPLIES

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: _____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 ***(99 = Lifetime)***

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	
	Pressure pad for mattress:
Y N D	Is the beneficiary completely immobile and cannot make changes in body position without assistance?
Y N D	Does the beneficiary have limited mobility and cannot independently make changes in body position significant enough to alleviate pressure?
Y N D	Does the beneficiary have a pressure ulcer (any stage) on the trunk or pelvis?
Y N D	Is the beneficiary essentially bed-bound and has impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status?
ANSWERS	**Power pressure reducing overlay or mattress:**
Y N D	Does the beneficiary have multiple stage II pressure ulcers located on the trunk or pelvis?
Y N D	Has the beneficiary been on a comprehensive ulcer treatment program and the ulcers have worsened or remained the same for a month?
Y N D	Does the beneficiary have large or multiple stage III or stage IV pressure ulcers on the trunk or pelvis?
Y N D	Has the beneficiary had a myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the previous 60 days? Enter date of surgery_____/____/______.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PROSTHETIC LIMBS

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	Prosthetic Limbs:
	Request for prosthetic limbs must include the following documentation: ▪ Summary statement of beneficiary's significant medical history, and ▪ Beneficiary's current condition including status of the residual limb.
Y N D	Can the beneficiary be expected to reach or maintain a defined functional state within a reasonable period of time?
Y N D	Is the beneficiary motivated to use the prosthesis as intended, e.g., ambulation?

PHYSICIAN ORDER: ***(Prosthetic limbs must be ordered by a physician who by special training in orthopedics, physiatry, or developmental pediatrics has acquired expertise to ensure that the ordered equipment is appropriate and properly fitted).***

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – PULSE OXIMETER AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ______________________________
Date of Birth: ___/___/___ Age:_____ Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: ______________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ____________________
Telephone #: (___) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ **1 – 99** ***(99 = Lifetime)***

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	
Y N D	Does the beneficiary have a documented serious respiratory diagnosis, which requires short-term oximetry to rule out hypoxemia and/or to determine the need for supplemental oxygen?
Y N D	Is the beneficiary dependent on a ventilator with supplemental oxygen?
Y N D	Does the beneficiary have a tracheostomy and requires monitoring of O2 saturation as determined by the physician?
Y N D	Does the beneficiary require supplemental oxygen and have unstable saturations?
Y N D	Is the beneficiary being weaned off of supplemental oxygen?
Y N D	If a recording pulse oximeter is requested, does the beneficiary require monitoring during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which the physician needs documentation of the patient's blood oxygen saturation?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________ ______________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – REFLUX SLING / WEDGE

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________	Ordering MD/NP/PA Name (First and Last):
Medicaid #: ____________________________________	____
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)	Medicaid ID# or MS License #: ___________________
HT: __________ (inches) WT: ___________ (lbs)	Telephone #: (____) ______-________ Ext. ______
Date of last visit: __________________________	

SECTION B — CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary less than twelve (12) months of age?
Y N D	Does the beneficiary require upper body elevation after feeding?
Y N D	Has the beneficiary's physician diagnosed any of the following conditions: (Check all that apply) ☐ Esophageal Reflux ☐ Perinatal Chronic Respiratory Disease ☐ Esophagitis ☐ Bronchopulmonary Dysplasia
Y N D	If the beneficiary does not have any of the above conditions, is there another condition(s) that necessitate the use of a reflux sling / wedge? If yes, record the condition(s): ______________________________________

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – ROOM PURIFIER

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): _______1 – 99 *(99 = Lifetime)*

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	
Y N D	Does the beneficiary have severe asthma?
Y N D	Does the beneficiary have severe respiratory disease such as recurrent bronchospasm?
Y N D	Does the beneficiary have other chronic severe lower respiratory conditions for which this equipment might be applicable?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

____ ____________________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SPECIALIZED REHABILITATIVE EQUIPMENT: FEEDER SEAT; CARRIER SEAT OR SHELL HELMETS

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: __________________________________ Date of Birth: ____/_____/____ Age: ______ Sex: _____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ________________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Tumble Form Feeder Seat:**
Y N D	Does the beneficiary require positioning for the purpose of feeding?
Y N D	Will the feeder seat be used as a mobility alternative for the beneficiary?
Y N D	Does the feeder seat include a floor sitter to ensure proper and stable positioning?
ANSWERS	**Carrier Seat:**
Y N D	Does the beneficiary have severe deformities or medical conditions that necessitate the use of a carrier seat for transporting the beneficiary? If yes, describe below. ____
ANSWERS	**Soft and Hard Shell Helmets:**
Y N D	Does the beneficiary have some type of deformity, injury, or self-abusive behavior? If yes, describe condition below. ____
Y N D	Is the beneficiary post-operative? If yes, record below the name and date of surgical procedure that was performed. ____

PHYSICIAN ORDER:

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

______________________________________ ________________

Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SPECIALIZED REHABILITATIVE EQUIPMENT: SIDE LYER

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY **Side Lyer:**
Y N D	Is the beneficiary severely handicapped?
Y N D	Can the beneficiary tolerate the upright positioning of a wheelchair throughout the day?
Y N D	Will the Side Lyer be used in places other than the home?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SPECIALIZED REHABILITATIVE EQUIPMENT: STANDING FRAMES

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________	Ordering MD Name (First and Last):
Medicaid #: ___________________________________	____
Date of Birth: ____/_____/____ Age:______ Sex: _____ (M or F)	Medicaid ID# or MS License #: ________________________
HT: __________ (inches) WT: ___________ (lbs)	Telephone #: (____) ______-________ Ext. ______
Date of last visit: _________________________	

SECTION B — CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY **Standing Frames:**
Y N D	Is the ordering physician an orthopedist, pediatrician, physiatrist, neurologist, or neurosurgeon?
Y N D	Is the bony alignment of the beneficiary's foot and ankle such that the foot and ankle can stand the beneficiary's weight?
Y N D	Is the beneficiary able to stand independently?
Y N D	Is the beneficiary able to ambulate independently?
Y N D	Will the standing frame be used at school?
Y N D	Will the standing frame be used in locations other than school? If yes, record examples of intended places of use below. ____
Y N D	Does the beneficiary need the advantages of weight bearing, e.g., aid in digestion, bone strengthening, etc.?
Y N D	Does the beneficiary require a tray? If yes, record medical rationale below. ____
Y N D	Will the beneficiary need caster bases attached to the standing frame? If yes, record medical rationale below. ____
Y N D	Will the beneficiary require the use of foot sandals and wedges? If yes, record medical rationale below. ____

PHYSICIAN ORDER:

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician   Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SPECIALIZED REHABILITATIVE EQUIPMENT: THERAPY WEDGE; THERAPY ROLL OR THERAPY BALL

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ____/_____/____ Age:______ Sex: _____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ________________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Tumble Form Therapy Wedge:**
Y N D	Does the beneficiary require positioning in the prone position? If yes, record medical rationale below. ____
Y N D	Will the beneficiary require a strap to maintain positioning on the wedge?
ANSWERS	**Tumble Form Therapy Roll:**
Y N D	Is the beneficiary involved in a program to enhance head and upper extremity control?
Y N D	Does the beneficiary require support and positioning of the head and upper extremity to facilitate therapy geared towards improving control?
ANSWERS	**Therapy Ball:**
Y N D	Is the beneficiary involved in therapy to improve the following: a) protective and righting reactions, b) trunk control, c) sitting balance, d) head control, e) other strengthening activities?
Y N D	Is the beneficiary to have a home therapy program? **NOTE: A request for this item requires submission of documentation that justifies the medical necessity for the therapy ball for use in the home.**
Y N D	Has the beneficiary's caregiver demonstrated proper use in the home setting *if the beneficiary is to have a home therapy program?*

PHYSICIAN ORDER:

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SPECIALIZED REHABILITATIVE EQUIPMENT: CORNER CHAIR OR FLOOR SITTER

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ______________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Corner Chair:**
Y N D	Does the beneficiary have decreased trunk control?
Y N D	Does the beneficiary require assistance with sitting balance and upper extremity use and control?
Y N D	Will any other type of seating accommodate the beneficiary's sitting balance and upper extremity use and control?
Y N D	Does the beneficiary have a floor sitter?
ANSWERS	**Floor Sitter:**
Y N D	Does the beneficiary have decreased trunk control and appropriate head control?
Y N D	Does the beneficiary require the use of a floor sitter to perform activities while sitting?
Y N D	Is the beneficiary receiving therapy to achieve greater independence in sitting balance?
Y N D	Does the beneficiary require a tray to successfully achieve independent upper extremity function?
Y N D	Does the beneficiary have a corner chair?
Y N D	Does the beneficiary require a roller-based attachment?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – EXTERNAL SPEECH PROCESSOR AND ACCESSORIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	**ICD-10-CM**

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	**CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY**
Y N D	Does the beneficiary have a cochlear implant? If yes, please provide the date of the surgery.______________________
Y N D	Is the ordering physician an otologist, otolaryngologist or other physician specialty who has documented training in assessment for and prescription of cochlear implant devices?

PHYSICIAN ORDER:

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The Physician order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SUCTION PUMPS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	RESPIRATORY SUCTION
Y N D	Is the beneficiary unable to clear the airway of secretions by coughing secondary to, but not limited to, one of the following:
Y N D	(a) Has the beneficiary had cancer or surgery of the throat?
Y N D	(b) Does the beneficiary have paralysis of the swallowing muscles?
Y N D	(c) Does the beneficiary have a tracheostomy?
Y N D	(d) Is the beneficiary in a comatose or semicomatose condition?
Y N D	Did the beneficiary/caregiver receive sufficient training in the appropriate use and safety of the equipment?
	GASTRIC SUCTION
Y N D	Does the beneficiary have one of the following conditions? Check all that apply. ☐ Gastric outlet obstruction and gastric atox ☐ High-grade esophageal stenosis or complete esophageal obstruction ☐ Enterocutaneous fistula not manageable by gravity tube drainage
Y N D	Does the beneficiary have a history of aspiration?
	Requests for a mobile (portable) unit must answer the following questions in additional to the appropriate questions above.
Y N D	Is the beneficiary subject to secretions that require suction during travel?
Y N D	Is the beneficiary being transported by ambulance?
Y N D	Does the beneficiary require a stationary and portable suction unit? If yes, provide clinical documentation, which indicates the medical necessity. ______________________________

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SUPPLIES
BEDPAN and URINAL

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary confined to the bed?
Y N D	Is the beneficiary able to use a bedside commode or bathroom facility?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SUPPLIES
DRESSING SUPPLIES FOR WOUND CARE

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a PEG tube?
Y N D	Are tube feedings the beneficiary's sole source of nutrition?
Y N D	Does the beneficiary have a wound? If yes, how often is the dressing changed? ________________________

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY
ENEMA SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary's condition require the introduction of solution(s) into the rectum and colon in order to stimulate bowel activity and cause emptying of the lower intestine?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – SUPPLIES
HEEL/ELBOW PROTECTORS or SHEEPSKIN

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ________________________________ Medicaid #: ______________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary confined to the bed/chair?
Y N D	Does the beneficiary currently have a decubitus ulcer on a heel or elbow?
Y N D	Does the beneficiary currently exhibit signs of redness or discomfort at bony prominences or other areas of potential breakdown?
Y N D	Does the beneficiary have a history of decubitus ulcers on a heel or elbow?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

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____ ____________________

Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY - SUPPLIES
INSULIN PEN NEEDLES or PREFILLED SYRINGE NEEDLES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary receiving a prefilled Novopen or cartridge through pharmacy program?
Y N D	Is the beneficiary unable to read the markings on a standard insulin syringe because of poor eyesight?
Y N D	Does the beneficiary have a condition of the hands that will not allow them to manipulate a vial and syringe to draw up their insulin?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY
OSTOMY SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have a surgically established opening (stoma) to divert urine, feces, or ileal contents outside the body?
_______	How often does the beneficiary change the appliance(s) to the stoma site?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY
TRACHEOSTOMY SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ________________________________ Medicaid #: ______________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	**ICD-10-CM**

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	**CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY**
Y N D	Does the beneficiary have a tracheostomy? If yes, document the specific respiratory condition: ______________________________________
__________	Date tracheostomy was performed.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY - SUPPLIES
URINARY CATHETERS

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have an acute condition which requires intermittent catheterization for measuring residual, instilling medication, or other medically necessary indication?
Y N D	Does the beneficiary have an acute condition which requires the short-term use of an indwelling catheter?
Y N D	Does the beneficiary have a chronic condition in which incontinence is exacerbating pressure sores that will not heal?
Y N D	Does the beneficiary have a condition that requires accurate measurement of intake and output on a short-term basis?
Y N D	Does the beneficiary have urinary retention that cannot be relieved by medication?
Y N D	Is the beneficiary and/or caregiver capable of performing the catheterization procedure and reporting results?
Y N D	Has the beneficiary and/or caregiver been instructed in the procedure and properly demonstrated the ability to perform the procedure?
Y N D	Does the beneficiary require a condom catheter for conditions such as paraplegia, neurogenic bladder, etc?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:
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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician / Nurse Practitioner / Physician Assistant___________________________ Date ________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – TENS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have acute post-operative pain?
___/___/___	What is the date of the surgery resulting in acute post-operative pain?
Y N D	Is the beneficiary being treated at home?
Y N D	Does the beneficiary have chronic intractable pain?
______ mo.	How long has the beneficiary had intractable pain? (Enter number of months, 1 – 99).
Y N D	Has the beneficiary failed to respond to other treatment modalities?
Y N D	Does the beneficiary require a conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes and lead wires?
Y N D	Does the beneficiary require a conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesives tapes, and lead wires?
Y N D	Does the beneficiary have a documented medical condition such as skin problems that preclude the application of conventional electrodes, adhesive tapes, and lead wires?
Y N D	Does the beneficiary require electrical stimulation beneath a cast to treat chronic intractable pain?
Y N D	Has the beneficiary completed a 30 - 60 day trial period? If yes, the physician must provide a copy of the re-evaluation performed at the end of the trial period and documentation that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.
Y N D	Is a four (4) lead TENS unit being ordered? If yes, document why two (2) leads are insufficient to meet the patient's needs: ____

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician/Nurse Practitioner/Physician Assistant___________________________ Date ___________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – TRACTION EQUIPMENT OR TRAPEZE BAR

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: _______________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	Traction Equipment:
Y N D	Does the beneficiary have a cervical or pelvic orthopedic impairment verified by radiographic documentation?
Y N D	Does the beneficiary have a documented history of chronic pain from an orthopedic impairment that has been unrelieved by other treatment modalities?
Y N D	Does the beneficiary have any other orthopedic impairment requiring traction? If yes, record:____
ANSWERS	**Free Standing or Attached Trapeze Bar:**
Y N D	Does the beneficiary have truncal or lower extremity weakness?
Y N D	Does the beneficiary require the device to achieve any of the following? ☐ Rise to sit ☐ Change body position ☐ Get in or out of bed
Y N D	Is the trapeze bar being used as an integral part of a hospital bed?
Y N D	If the above question was answered "yes," has the hospital bed been determined to be medically necessary?
Y N D	Does the beneficiary own or rent a hospital bed?
Y N D	If the beneficiary owns or rents a hospital bed, will the trapeze bar be used with the bed?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER: ***(Traction equipment must be ordered by an orthopedic physician, neurosurgeon, neurologist, or a physiatrist)***

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Physician/Nurse Practitioner/Physician Assistant_________________________________ Date _____________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – TRANSFER BOARDS

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
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Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have decreased or absent lower extremity function?
Y N D	Is the beneficiary obese and unable to transfer without lifting?
Y N D	Is the equipment needed to assist with the bed mobility of the beneficiary?
Y N D	Is the caregiver unable to lift the beneficiary for transfer?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – ULTRAVIOLET CABINET

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ___________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Does the beneficiary have generalized intractable psoriasis?
Y N D	Has the physician determined that medical and other factors justify treatment at home, rather than at an alternative site, (i.e. outpatient department of the hospital)?
Y N D	Is ultraviolet therapy available in the local area?
Y N D	Has the beneficiary and/or caregiver been trained and is capable of safely operating the equipment?
Y N D	Is the frequency of treatment such that home phototherapy is cost effective?
Y N D	Has the beneficiary completed a three (3) month trial period and does the physician certify that the treatments were effective and the beneficiary was compliant with the use of the equipment?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – VENTILATORS AND/OR PRESSURE SUPPORT VENTILATORS AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ______________________________
Date of Birth: ____/_____/____ Age:______ Sex: _____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ________________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Ventilators:**
Y N D	Is the beneficiary unable to maintain spontaneous respiration?
Y N D	Is the beneficiary unable to maintain safe levels of arterial carbon dioxide or oxygen with spontaneous breathing?
Y N D	Does the beneficiary have a medical condition that requires mechanically assisted ventilation that is appropriate for home use without continuous technical or professional supervision? If yes, please list. ________________________________
_____ hr.	How many hours per day is ventilation required?
ANSWERS	**Pressure Support Ventilator (PSV):**
Y N D	Is the PSV primarily intended to augment beneficiary ventilation 12 hours a day or less?
Y N D	Did beneficiary experience a trial period with a pressure support ventilator?
Y N D	What are the dates the trial began ___/___/___ and ended ___/___/___?
Y N D	Does the beneficiary have chronic respiratory failure with hypercapnia secondary, but not limited to, Chronic Obstructive Pulmonary Disorders?
Y N D	Does the beneficiary have Disorders of Ventilatory Control?
Y N D	Does the beneficiary have Musculoskeletal Disorders?
Y N D	Does the beneficiary have Neuromuscular Disorders?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

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eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WALKER AND RELATED SUPPLIES

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B — CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY **Complete following questions for all walker requests:**
Y N D	Does the beneficiary have a medical condition, which causes impaired ambulation, but there is potential for the beneficiary to ambulate?
Y N D	Does the beneficiary require more stability and security than can be provided by canes or crutches?
Y N D	If a seat attachment is ordered, does the beneficiary require rest periods during ambulation to conserve energy and maintain endurance?
Y N D	If platform attachments are ordered, is one or both of the beneficiary’s upper extremities compromised?
Y N D	If leg extensions are ordered, do they allow for growth for children?
Y N D	Is the beneficiary able to maintain balance while picking up the walker and moving it forward?
Y N D	Does the beneficiary and/or caregiver have an appropriate means to transport the walker?
Y N D	Does the beneficiary have impaired lower extremity weight bearing ability (ex: spinal cord injury, cerebral palsy, congestive heart failure, stroke, post-operative conditions)?
Y N D	Does the beneficiary have impaired balance during ambulation?
Y N D	Does the beneficiary require ambulation training, such as newly braced children, adults in rehabilitation, and other diagnoses as medically necessary?
Y N D	Is the beneficiary able to maintain balance during ambulation with the rolling motion?
Y N D	Is the beneficiary large/obese or unable to use a standard walker due to severe neurological disorders or restricted use of one hand?
Y N D	Does the beneficiary’s gait pattern apply excessive force on the walker or is the beneficiary at risk for falls?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

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Signature of Physician / Nurse Practitioner / Physician Assistant — Date

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS ACCESSORIES AND OPTIONS I

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Amputee Adapter (pair):**
Y N D	Has the beneficiary had an amputation of one or both lower extremities?
ANSWERS	**Armrest/Arm Support:**
Y N D	Is the beneficiary capable of performing side transfers independently or with assistance?
ANSWERS	**Arm Trough:**
Y N D	Does the beneficiary have spasticity or decreased strength or tone in an upper extremity?
Y N D	Is the arm trough needed for positioning to increase function or to decrease possible damage to an upper extremity?
ANSWERS	**Anti-Roll Back Device:**
Y N D	Does the beneficiary have assistance operating the wheelchair and meets the criteria for a manual chair?
ANSWERS	**Reinforced Back and Seat Upholstery:**
Y N D	Is the beneficiary morbidly obese and requires a more stable base?
Y N D	Does the beneficiary have an excessive movement disorder?
ANSWERS	**Cylinder Tank Carrier:**
Y N D	Does the beneficiary require constant or intermittent oxygen?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS ACCESSORIES AND OPTIONS II

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Fully Reclining Back:**
Y N D	Is the beneficiary a quadriplegic?
Y N D	Does the beneficiary have a fixed hip angle at a ninety-degree angle?
Y N D	Does the beneficiary have a cast/brace on a lower extremity that requires a reclining back for positioning?
Y N D	Does the beneficiary need to rest in a recumbent position two or more times a day?
Y N D	Is transfer between bed and chair difficult? If yes, specify reason: ____
ANSWERS	**Solid Back Insert, Planar Back, Single Density Foam OR Attached Straps:**
Y N D	Does the beneficiary use a sling seating system when the back is slung and does the beneficiary required increased support?
Y N D	Does the equipment allow for growth in a sling system (since it may add up to 1 ½ inches in growing room to the thigh area)?
ANSWERS	**Footrest, High Mount, Flip Up:**
Y N D	Does the recipient have a lower leg measurement (knee to foot) that prevents them from using the manufactured mounting?
ANSWERS	**Footrest, Lower Extension Tubes (each):**
Y N D	Is the beneficiary growing and will the beneficiary need the adjustability of lowering the footrest for growth?
Y N D	Does the beneficiary have a leg length difference and does the beneficiary need the footrest to be mounted at different heights?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS ACCESSORIES AND OPTIONS III

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Footplate, Adjustable Angle (each):**
Y N D	Does the beneficiary have a fixed dorsiflexion or plantar fixation contracture?
Y N D	Does the beneficiary have the tendency to develop pressure problems on the plantar surface of the foot?
ANSWERS	**Heel Loops:**
Y N D	Is the beneficiary seated in a tilt in space wheelchair?
Y N D	Does the beneficiary have poor lower extremity muscular function and need the support of the heel loop to keep the foot in place on the footrest?
Y N D	Does the beneficiary need the added support of a heel loop to assist in positioning of the lower extremities?
ANSWERS	**Heel Loops with Ankle Straps:**
Y N D	Can the beneficiary control the movement of his/her lower extremities to position the foot and ankle?
Y N D	Is the beneficiary seated in a tilt in space wheelchair?
Y N D	Can the beneficiary maintain adequate positioning of the foot and ankle without an ankle strap?
Y N D	Does the beneficiary have large feet or does the beneficiary move his/her feet excessively?
ANSWERS	**IV Hanger:**
Y N D	Does the beneficiary require continuous/intermittent IV or IV(s) or tube feedings?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS ACCESSORIES AND OPTIONS IV

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________
Medicaid #: ________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Hook On Headrest Extension:**
Y N D	Does the beneficiary have poor head/neck control and is the beneficiary seated in a sling seating system?
Y N D	Does the beneficiary require the use of a headrest for safety during transportation?
Y N D	Does the beneficiary have frequent seizures?
Y N D	Does the beneficiary have a reclining back wheelchair and does the beneficiary require support for the head and neck?
ANSWERS	**Legrest, Elevating:**
Y N D	Does the beneficiary have a musculoskeletal condition or the presence of a cast or brace, which prevents 90-degree flexion of the knees?
Y N D	Does the beneficiary have significant edema of the lower extremities that requires elevation?
Y N D	Does the beneficiary have a reclining back on the wheelchair?
Y N D	Is a calf pad needed to support the calf when using an elevated legrest?
ANSWERS	**Leg Strap:**
Y N D	Does the beneficiary have a tilt in space wheelchair and is the strap needed to prevent the lower extremity (ies) from falling backwards into the wheelchair?
Y N D	Does the beneficiary have increased or excessive extensor tones in the lower extremities and is the strap in front of the lower extremities to prevent them from extending forward?
Y N D	Does the beneficiary have muscle spasms of the lower extremities and will the strap help to keep the feet positioned on the footplates?
ANSWERS	**Leg Strap H Style (each):**
Y N D	Does the beneficiary require added support that is not supplied by the single leg strap?
Y N D	Does the beneficiary have a movement disorder that requires added reinforcement of the H strap configuration?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS ACCESSORIES AND OPTIONS V

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________
Medicaid #: ____________________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)
HT: __________ (inches) WT: ___________ (lbs)
Date of last visit: __________________________

Ordering MD/NP/PA Name (First and Last):
____
Medicaid ID# or MS License #: ___________________
Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Lower Pressure and Positioning Equalizing Pads:**
Y N D	Does the beneficiary have a history of pressure sores or decubitus ulcers?
Y N D	Does the beneficiary have pelvic obliquity?
Y N D	Is the beneficiary very thin and subject to pressure problems secondary to decreased adipose tissue at the bony prominences?
Y N D	Is the beneficiary able to move his/her trunk and/or lower extremities due to a spinal cord injury, whether from birth (myelomeningocele) or through an accident?
Y N D	Does the beneficiary have decreased or no sensation in the trunk and/or lower extremities?
ANSWERS	**One Arm Drive Attachment:**
Y N D	Does the beneficiary have functional use of only one upper extremity?
Y N D	Does the beneficiary have sufficient cognition, dexterity and endurance to use this item?
ANSWERS	**Shoeholder:**
Y N D	Does the beneficiary require the added support of a hard surface to position the foot?
Y N D	Does the beneficiary have excessive movement of the lower extremity (ies), athetosis or have a flexible ankle contracture?
ANSWERS	**Safety Belt / Pelvic Strap:**
Y N D	Are these items needed in addition to the standard safety belt?
Y N D	Are these items needed to maintain a neutral position of the pelvis when the beneficiary is seated in a wheelchair?
Y N D	Does the beneficiary have increased extensor tone?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_Signature of Physician / Nurse Practitioner / Physician Assistant Date ____________________

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS ACCESSORIES AND OPTIONS VI

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: ___________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
ANSWERS	**Toe Loop:**
Y N D	Does the beneficiary require the cover of the forefoot to keep the foot positioned on the footplate?
ANSWERS	**Wheelchair Tray:**
Y N D	Is the tray required to assist with positioning of the trunk and upper extremities?
ANSWERS	**Wheel Lock Extension (pair):**
Y N D	Does the beneficiary have functional use of one upper extremity?
Y N D	Does the beneficiary have decreased strength and need the extra height of the locks to achieve a greater lever arm for independent use of the wheel locks?
ANSWERS	**Wheel Lock Assembly (automatic):**
Y N D	Does the beneficiary have significant upper extremity disability or weakness and can the beneficiary operate manual locks?
Y N D	Does the beneficiary have the cognitive awareness to operate manual locks?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY –CUSTOM WHEELCHAIR; DRIVERS AND SEATING SYSTEMS

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ____________________ Telephone #: (____) ______-________ Ext. ______

SECTION B CLINICAL INFORMATION
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___ 1 – 99 *(99 = Lifetime)*

ANSWERS	Complete the following questions: Circle Y (Yes) - N (No) – or D (Does Not Apply)
Y N D	Is the beneficiary's medical condition such that no other type of wheelchair can be utilized?
Y N D	Does the ordering physician have experience in evaluating the beneficiary's specialized needs for the purpose of prescribing the customization features?
ANSWERS	**Seating System**
Y N D	Does the beneficiary require a seating system?
Y N D	Does the recommended seating system allow for growth of the beneficiary?
Y N D	Has a physical or occupational therapist that is not employed by the DME supplier or the manufacturer performed the seating evaluation? If yes, submit a copy along with this request for certification.
ANSWERS	**Motorized/Power Wheelchair**
Y N D	Does the beneficiary have a severe abnormal upper extremity dysfunction or weakness?
Y N D	Does the beneficiary have sufficient eye/hand perceptual capabilities to operate a motorized chair and the cognitive skills to safely guide it independently?
Y N D	Is the beneficiary capable of some activity to which the motorized chair will provide access?
Y N D	Is there an expectation that the wheelchair will continue to be appropriate for a minimum of five years?
ANSWERS	**Wheelchair Drivers**
Y N D	Does the beneficiary have a medical condition which justifies the medical necessity for a wheelchair driver? Please explain:
Y N D	Has a physical or occupational therapist, not employed by the DME supplier or the manufacturer, performed a face to face evaluation? If yes, submit a copy of the driver evaluation form along with this request for certification.
Y N D	Has an evaluation determined that the beneficiary is physically unable to manage the wheelchair without the assistance of this electronic interphase?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

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____ __________________
Signature of Physician / Nurse Practitioner / Physician Assistant Date

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHEELCHAIRS: NON-CUSTOM

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ______________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary's condition such that without the use of a wheelchair he/she would be otherwise restricted by inability to ambulate or transfer from one place to another?
Y N D	Is there an expectation that the wheelchair will continue to be appropriate for a minimum of three years?
ANSWERS	**Amputee Wheelchair:**
Y N D	Has the beneficiary had an amputation of one or both lower extremities?
ANSWERS	**Heavy Duty or Extra Heavy Duty Wheelchair:**
Y N D	Does the beneficiary require extra reinforcement due to severe spasticity?
WT:_______	Document specific weight or measurements that cause the beneficiary to require this type chair or the specific condition that would cause the beneficiary to be unable to function with a standard wheelchair:
ANSWERS	**Hemi; High Strength Lightweight or Ultra Lightweight Wheelchairs:**
Y N D	Is the beneficiary less than 21 years old? If yes, documentation substantiating the medical necessity for this type of wheelchair must be submitted along with this request for certification.
ANSWERS	**Lightweight Wheelchair**
Y N D	Can the beneficiary self-propel in a standard wheelchair using arms and/or legs?
Y N D	Is the beneficiary able to self-propel in a lightweight wheelchair?
ANSWERS	**Motorized Wheelchair:**
Y N D	Does the beneficiary have a severe abnormal upper extremity dysfunction or weakness?
Y N D	Does the beneficiary have sufficient eye/hand perceptual capabilities to operate a motorized chair and the cognitive skills to guide it independently?
Y N D	Is the beneficiary's home such that a motorized wheelchair can be used, i.e., ramps, appropriate covered transport for the chair?
Y N D	Is there an expectation that the wheelchair will continue to be appropriate for a minimum of five years?
ANSWERS	**Tilt In Space Wheelchair:**
Y N D	Does the beneficiary have increased spasticity or extensor tone, decreased or poor head or trunk control, progressive disease such as muscular dystrophy or needs to be tilted to assist with feeding and/or digestion?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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____ _______________

eQHealth Solutions Medicaid
Seating and/or Drivers Evaluation/Justification Form

Beneficiary and Provider Information

Beneficiary Medicaid #: ______	DME Provider MS Medicaid #: ______
Beneficiary Name: ______	DME Provider Name: ______
Date of Birth: ____ / ____ / ____ Sex: (M or F) ____	Ordering MD: ______
Age: ______ Height: ______ Weight: ______	

History

Diagnosis: ______
Past Medical History: ______
Past Surgeries: ______

Environmental Factors

Please check appropriate answer:

Yes	**No**	Residence: ☐ House ☐ Mobile Home ☐ Apartment ☐ Other (Specify):
		Steps/Stairs? How many are present?
		Ramp?
		Attends ☐ school ☐ daycare?
		Is school/daycare wheelchair accessible?
		Physical Therapy? Where? *(Please specify)*

Place wheelchair will be stored? ______
Provide approximate width of doorways: ______

Transportation

Child transported to school/daycare/community by *(provide vehicle make and model):* ______
If truck, is it covered? ☐ Yes ☐ No If yes, specify type of covering: ______
Is ramp available for transportation? ☐ Yes ☐ No Wheelchair restrained in vehicle by: ______

Physical Assessment – Posture, Movement and Function

Posture in Present Seating/Mobility System

Does beneficiary presently have a wheelchair? ☐ Yes ☐ No
If yes, please indicate type and when obtained ______
Does beneficiary presently have any other mobility device *(i.e. stroller)*? ☐ Yes ☐ No
If yes, please list: ______

Describe the beneficiary posture in their present seating/mobility system, include the following areas: pelvis/low back, trunk, hips and legs, knees, ankles and feet, head and neck, shoulder girdles and arms. **If applicable, also address why current mobility system does not meet the beneficiary's needs.**

Beneficiary ____________________ Medicaid # ____________

Functional Skills

(Document the amount of assistance needed, changes in posture and movement)

Activity	None	Minimum	Moderate	Maximum	Comments
Transfer to and from bed					
Transfer to and from car					
Transfer to and from floor					
Transfer to and from same level surface					
Self Care					
Dressing					
Bathing					
Eating					

Please describe the following activities:

Tabletop: ____________________

Work/vocational/home: ____________________

Please answer appropriately:

Is the patient ambulatory? ☐ Yes ☐ No Distance: __________ If yes, is assistance needed? ☐ Yes ☐ No

Level of Assistance: __________ Assistive Device(s): __________

Present Seating/Mobility System

Self Propelled

Beneficiary able to propel: ☐ Yes ☐ No

If yes, please specify: ☐ Short or ☐ Long distance

Time to push distance of 5 feet: __________

On what types of surfaces is the beneficiary independent?

(Check all that apply)

☐ Ramp ☐ Gravel ☐ Uneven Ground ☐ Grass

☐ Other: __________

Posture and movement when propelling: __________

Power wheelchair

Wheelchair is ☐ beneficiary or ☐ attendant operated?

Handle height: __________

Access method for control/switches? __________

Posture and movement when operating: __________

Communication: *(Describe any device and where it is mounted)* __________

Trunk and Pelvis

Is Condition Present?	Yes	No	If Yes, Check One: Fixed	If Yes, Check One: Flexible
Spinal deformity of kyphosis				
Spinal deformity of lordosis				
Spinal deformity of scoliosis				
Pelvic obliquity is present with the left/right ASIS higher/lower, forward/backward of the left/right ASIS				
Leg length discrepancy is noted with the left/right leg being longer				
Windblown hips to the left/right				
Dislocation of the left/right/both hips *(Must be confirmed by a physician)*				

Balance and Postural Control in Sitting

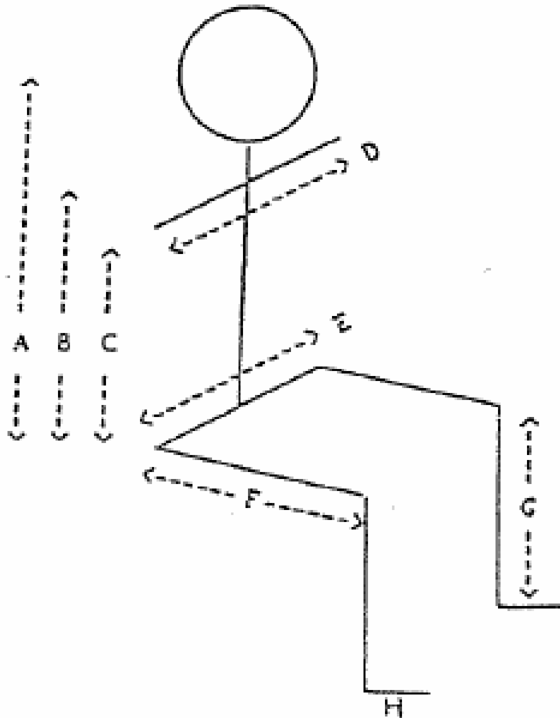
Balance Sitting:	Head Control:	Trunk Control:
☐ Good ☐ Fair ☐ Poor	☐ Good ☐ Fair ☐ Poor	☐ Good ☐ Fair ☐ Poor

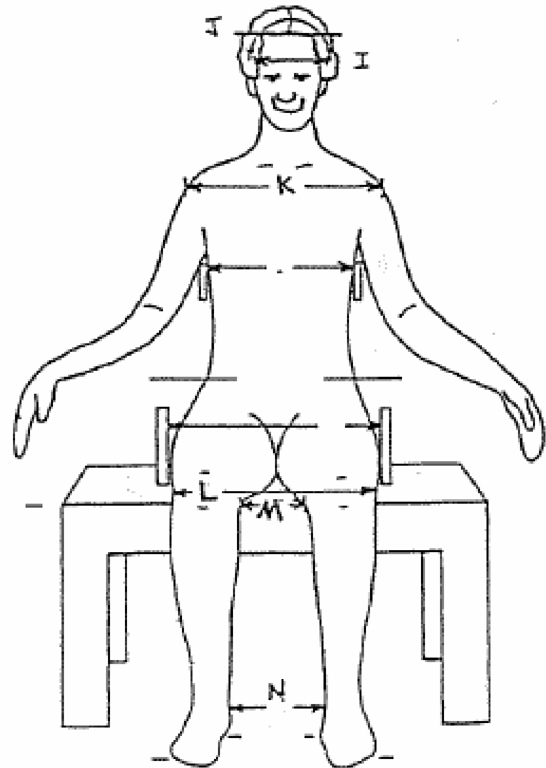
Beneficiary ______________________________ Medicaid # __________________

Assessment in Sitting
Describe any range of motion limitations *(spasticity, contractures, tone, associated reactions or reflexes affecting movement or posture):*

Measurements *(Please complete all areas)*

	Left	Right		Length	Width	Depth
Seat to Shoulder (B)			Chest (D)			
Seat to Axilla (C)			Hip (E) *(measuring largest part)*			
Thigh Length (F)			Foot (H)			
Lower Leg Length (G)			Head (J)			
Seat to top of head: (A) ______			Outside Shoulder (K)			
Head Circumference: (I) ______			Outer Knee (L) *(relaxed w/ knees apart)*			
Does Ankle width include bracing or shoes?			Inner Knee (M)			
☐ Yes ☐ No			Ankle (N)			
			Between Ankles			





Beneficiary ________________________________ Medicaid # __________________

Recommended Mobility Base and Components		
☐ Manual ☐ Power	Caster	
Frame Type ____________ Frame Width ____________	Wheel	
Tilt ____________ Recline ____________	Front Riggings/Footplate	
Seat Depth ____________ Back Height ____________	Wheel Locks	
☐ Short ☐ Medium ☐ Long	Arm	
Adjustability of components/angles *(Growth potential – width, depth, height):*	Handrim	
	Cushion Covering	
	Tire	
	Power wheel chair drive control	
	Headrest	

Yes	No	Please check appropriate answer:
		Is wheelchair foldable?
		Will it fit in the family vehicle?
		Can beneficiary/family independently adjust or remove seating/mobility components?
		Is seating system removable from mobility system?
		Has the beneficiary undergone a trial with the same or similar wheelchair? *(If yes, document results below)*
		If wheelchair type is power, is there a power proficiency evaluation available? *(Attach copy)*
		Was pressure mapping done? *(Attach copy)*
		Does the structure of the residence support the weight of the wheelchair?
		Does wheelchair fit through all doorways of residence?

Wheelchair Drivers (please check appropriate answer)		
Yes	**No**	**Joystick (hand or foot operated)**
		Can the beneficiary manipulate the joystick with fingers, hand, arm, foot, etc?
		Has the beneficiary safely demonstrated operating the motorized chair with an extremity using a joystick?
Yes	**No**	**Chin Control**
		Does the beneficiary have a medical condition which prevents the use of their hands/arm, but is able to move their chin?
		Has the beneficiary safely demonstrated operating the motorized chair with the manipulation of the chin control device?
Yes	**No**	**Head Control**
		Does the beneficiary have a medical condition which prevents the use of their hands/arms, but is able to move their head freely with control of their head?
		Has the beneficiary safely demonstrated operating the motorized chair with the manipulation of the head control device?
Yes	**No**	**Extremity Control**
		Does the beneficiary have a medical condition which prevents or limits fine motor skills during the use of their extremities, but is able to move their hands/arms/legs?
		Has the beneficiary safely demonstrated operating the motorized chair with the manipulation of the extremity control device?
Yes	**No**	**Sip and Puff features**
		Is the beneficiary able to move their body at all?
		Can the beneficiary operate any other driver?
		Has the beneficiary safely demonstrated operating the motorized chair with the manipulation of the Sip and Puff control?

Beneficiary ______________________ Medicaid # ______________

Miscellaneous ***(Specify Custom Seating)*****:** ______________

Recommendation
Upon evaluation the most appropriate wheelchair is: ______________
Justification *(List all components of wheelchair and necessity of each as it related to this beneficiary. Mention potential for growth, improved function. Refer to DOM's Medical Review Policy for criteria coverage):*

I certify that I am the therapist who evaluated this beneficiary, in the presence of: ______________
(*Caregiver/Family Member – Relationship)*

Based on my evaluation, I have recommended the wheelchair and/or seating system listed on page 4 of this form. My recommendations are based on this beneficiary's measurements and individual needs, as of this date, and is the most appropriate. I further certify that the information provided on this form is true, accurate and complete to the best of my knowledge. The seating/mobility system is to be fitted by the DME vendor indicated on page 1 of this form and upon delivery of the wheelchair, my representative, or I will be present.

______________________ ______________

Signature of Occupational/Physical Therapist **Date**

I hereby certify that ______________________ or the manufacturer does not employ the therapist who
(DME Provider Name)
evaluated this beneficiary for the custom wheelchair and/or seating system. I further certify that the seating/mobility system will be delivered to the beneficiary exactly as recommended by the therapist on page 4 of this form.

______________________ ______________

Signature of DME Supplier **Date**

eQHEALTH SOLUTIONS CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATION OF THE MEDICAID PROGRAM.

eQHealth Solutions

CERTIFICATE OF MEDICAL NECESSITY – WHIRLPOOL EQUIPMENT

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: ______________________________ Medicaid #: ____________________________________ Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F) HT: __________ (inches) WT: ___________ (lbs) Date of last visit: __________________________	Ordering MD/NP/PA Name (First and Last): ____ Medicaid ID# or MS License #: ___________________ Telephone #: (____) ______-________ Ext. ______

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-10-CM

Est. Length of Need (# of Months): ___1 – 99 ***(99 = Lifetime)***

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
Y N D	Is the beneficiary homebound?
Y N D	Does the beneficiary have a medical condition for which the whirlpool bath can be expected to provide substantial therapeutic benefit justifying it's cost?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

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The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

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 durable medical equipment, orthotics, prosthetics, or medical supplies, 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 ordering physician/nurse practitioner/physician assistant identified in Section A 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 certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

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Signature of Physician / Nurse Practitioner / Physician Assistant Date