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):

____

Mississippi Medicaid ID#: _________________________

Ordering MD/NP/PA NPI#:__________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:_______________________

Collaborating Physician's MS Medicaid#:_______________

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 dose 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:

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 - 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):

____

Mississippi Medicaid ID#: ___________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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:

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 - 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/NP/PA Name (First and Last):

____

Mississippi Medicaid ID#: ___________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only
Collaborating Physician's NPI#:________________________
Collaborating Physician's MS Medicaid#:________________

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
	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 / 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 - 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/NP/PA Name (First and Last):

____

Mississippi Medicaid ID#: ___________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:_______________________

Collaborating Physician's MS Medicaid#:________________

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 / 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 - 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):

____

Mississippi Medicaid ID#: __________________________

Ordering MD/NP/PA NPI#:__________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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:

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 - 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):

____

Mississippi Medicaid ID#: ___________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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:

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: ______________________________	Ordering MD/NP/PA Name (First and Last): ______________________________
Medicaid #: ____________________________________	Mississippi Medicaid ID#: _________________________
Date of Birth: ___/____/___ Age:_____Sex: ____ (M or F)	Ordering MD/NP/PA NPI#: _________________________
HT: __________ (inches) WT: ___________ (lbs)	Telephone #: (_____) _______-__________ Ext._______
Date of last visit: ___________________________	**Nurse Practitioners (NP)/Physician Assistants (PA) Only**
	Collaborating Physician's NPI#:_______________________
	Collaborating Physician's MS Medicaid#:_________________

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 in 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:

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 - 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):

____

Mississippi Medicaid ID#: __________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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:

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 - 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):

____

Mississippi Medicaid ID#: __________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:_______________________

Collaborating Physician's MS Medicaid#:________________

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:

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 - PNEUMATIC COMPRESSOR/LYMPHEDEMA PUMP 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):

____

Mississippi Medicaid ID#: _________________________

Ordering MD/NP/PA NPI#:_________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:______________________

Collaborating Physician's MS Medicaid#:_______________

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:

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 - POSTURAL DRAINAGE BOARD AND RELATED SUPPLIES

SECTION A — BENEFICIARY AND PROVIDER INFORMATION

Patient/Baby Name: ________________________________	Ordering MD/NP/PA Name (First and Last): ____________________________________
Medicaid #: ______________________________________	Mississippi Medicaid ID#: ___________________________
Date of Birth: ___/____/___ Age:_____ Sex:_____ (M or F)	Ordering MD/NP/PA NPI#:___________________________
HT: __________ (inches) WT: ___________ (lbs)	Telephone #: (_____) ______-___________ Ext.________
Date of last visit: __________________________________	**Nurse Practitioners (NP)/Physician Assistants (PA) Only** Collaborating Physician's NPI#:_________________________ Collaborating Physician's MS Medicaid#:________________

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:

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 - 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):

____

Mississippi Medicaid ID#: __________________________

Ordering MD/NP/PA NPI#:__________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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:

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):

____

Mississippi Medicaid ID#:__________________________

Ordering MD/NP/PA NPI#: _________________________

Telephone #: (_____) _______-__________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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
	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.

____ ______________________

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):

____

Mississippi Medicaid ID#:________________________

Ordering MD/NP/PA NPI#: ________________________

Telephone #: (_____) _______-_________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:_______________________

Collaborating Physician's MS Medicaid#:_______________

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.

____ ____________________

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/NP/PA Name (First and Last):

____

Mississippi Medicaid ID#: __________________________

Ordering MD/NP/PA NPI#:___________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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 / NURSE PRACTITIONER / PHYSICIAN ASSISTANT 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).*

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 – 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):

____

Mississippi Medicaid ID#:___________________________

Ordering MD/NP/PA NPI#: _________________________

Telephone #: (_____) _______-__________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:_________________

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 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:

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: ______________________________

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):

____

Mississippi Medicaid ID#: ______________________________

Ordering MD/NP/PA NPI#:______________________________

Telephone #: (_____) ______-___________ Ext.________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:________________________

Collaborating Physician's MS Medicaid#:________________

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:

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 – 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/NP/PA Name (First and Last):

____

Mississippi Medicaid ID#: ________________________

Ordering MD/NP/PA NPI#:________________________

Telephone #: (_____) _______-_________ Ext. ________

Nurse Practitioners (NP)/Physician Assistants (PA) Only

Collaborating Physician's NPI#:_______________________

Collaborating Physician's MS Medicaid#:________________

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 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