

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM  
FOR EQUIPMENT/ SUPPLIES**

**CERTIFICATION TYPE / DATE:** INITIAL \_\_\_/\_\_\_/\_\_\_ REVISED \_\_\_/\_\_\_/\_\_\_ RECERTIFICATION \_\_\_/\_\_\_/\_\_\_

**SECTION A: TO BE COMPLETED BY PROVIDER:**

- (1) Recipient's name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_
- (2) Recipient's Medicaid # (10 digits): \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_
- (3) Date of (telephone/written/fax) order: \_\_\_\_\_ Date of service: \_\_\_\_\_
- (4) Provider's name: \_\_\_\_\_ Provider's DME # \_\_\_\_\_
- (5) Provider's signature: \_\_\_\_\_ Date: \_\_\_\_\_
- (6) Street address: \_\_\_\_\_ City: \_\_\_\_\_
- (7) State: \_\_\_\_\_ Zip: \_\_\_\_\_ Local telephone # \_\_\_\_\_
- (8) Diagnosis codes (ICD-9) \_\_\_\_\_ (Descriptions): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- (9) Print treating/ordering physician's name: \_\_\_\_\_ License # \_\_\_\_\_
- (10) SPECIFICALLY LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT ON THE BACK OF THIS FORM.

NOTE: ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISH PRICE, MUST INCLUDE MANUFACTURER PRICE LIST. RECERTIFICATION IS REQUIRED PRIOR TO EXPIRATION OF THE CURRENT CMN/AF FOR RENTAL ITEM(S).

**SECTION B: TO BE COMPLETED BY TREATING/ORDERING PHYSICIAN ONLY**

(11) Indicate patient's ambulatory status while performing activities of daily living: \_\_\_ No, Non-ambulatory \_\_\_ Yes, without assistance \_\_\_ Yes, with the aid of a walker or cane.

Is the patient susceptible to or have decubitus ulcers? \_\_\_ Yes \_\_\_ No. If yes, circle stage(s): I, II, III, or IV.

Can the patient safely and effectively use the equipment ordered? \_\_\_ Yes \_\_\_ No. If no, please explain: \_\_\_\_\_

State the recipient's expected prognosis as it relates to the equipment/supplies prescribed: \_\_\_\_\_

Oxygen levels: SaO2 \_\_\_\_\_ PaO2 \_\_\_\_\_

Is additional information attached on separate sheet? \_\_\_ Yes \_\_\_ No (If "yes", enter recipient's name & I.D. Medicaid number on attachment)

(12) Date last seen or evaluated by treating/ordering physician: \_\_\_\_\_

(13) Duration of need (maximum of 12 months): \_\_\_\_\_

(If duration is less than 12 months, please indicate)

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability.

(14) PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_ (SIGNATURE AND DATES STAMPS ARE NOT ACCEPTABLE)

