ATTENTION PHYSICIANS AND SUPPLIERS

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**Special Bulletin**

**CMN REVISIONS FINALIZED**

The following pages contain instructions for use of the finalized Certificates of Medical Necessity (CMNs) version .02. Originals of the CMNs begin on page 96-242. You may photocopy these to use as appropriate.

**Use of version .02 CMNs is required by August 1, 1996.**

Palmetto GBA also will be releasing a revision to the DMERC Region C DMEPOS Supplier Manual which will contain instructions for, and loose leaf originals of, version .02 CMNs.

Contact your ombudsman with questions regarding the finalized CMNs. A directory of Region C Ombudsmen can be found on page 96-272.
HCFA Responds to Supplier Comments

In response to comments from suppliers, version .02 Certificates of Medical Necessity (CMNs) have been revised. Most of the CMNs have been converted from two-pages to one. However, DMERC 02.02A (Motorized Wheelchairs) and 02.02B (Manual Wheelchairs) remain two-page CMNs.

The revised CMNs have been given a HCFA form number (HCFA 841-853) in addition to the DMERC form number. (See sidebar.) The HCFA form number is in the bottom left corner of the form.

The revised CMNs will be referred to by their HCFA form numbers. The DMERC form numbers will identify the CMN on electronic claims submitted to the DMERC in the NSF format.

DMERC 08.02, the DMERC Information Form (DIF) for Immunosuppressive Drugs, has not been changed. Form 484 also was not revised and continues to serve as the CMN for Home Oxygen Therapy.

For electronic submitters, the revised CMNs will not require any change to the .02 version of the NSF format available since last summer. Vendors will have to test the version .02 format with the DMERC if they have not done so already.

HCFA forms 841-853 may be submitted with claims beginning immediately. Prior version .02 CMNs and version .01 CMNs are temporarily acceptable. However, HCFA forms 841-853 will be REQUIRED with claims received by the DMERC on or after August 1, 1996. Version .01 CMNs and prior version .02 CMNs will NOT BE ACCEPTABLE as CERTIFYING MEDICAL NECESSITY WITH CLAIMS RECEIVED ON OR AFTER AUGUST 1, 1996.

Section A
Section A, which may be completed by suppliers, has been revised on all CMNs. Certain fields (e.g., warranty information) have been eliminated and other fields which previously required physician completion (e.g., physician name, address, UPIN and phone number) have been moved to Section A. The list of codes on page 96-240 are those which require a CMN. They are the codes that should be listed in Section A of the CMN. CMNs must accompany claims for purchase of these items (including replacement), the first month's rental of equipment, the initial provision of PEN nutrients and supplies, and any required revised certifications or recertifications. Submitting CMNs when they are NOT required (e.g., subsequent months on rental items, oxygen, or PEN nutrients when there is no change in the order and no requirement for recertification) may cause claims processing problems or delays, and is discouraged.

Section B
Section B may NOT be completed by the supplier on any version .02 CMN, including PEN CMNs. Section B may be completed by the physician, the physician's employee or another clinician involved in the

<table>
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care of the patient (e.g., nurse, physical or occupational therapist, etc.), **AS LONG AS THAT PERSON IS NOT THE SUPPLIER**. There are no changes to the questions in Section B of any CMN compared to the prior version .02 CMNs.

**Section C**

Section C reflects the requirements of the 1994 Amendments to the Social Security Act. It provides an opportunity for the ordering physician to review and confirm a detailed description of the items provided. It also indicates the supplier's charge and what the Medicare fee schedule allowance will be, if applicable. Section C contains a blank space that can be formatted in different ways. However, the following guidelines must be met:

- The description of the item provided must include not only those items listed in Section A of the CMN, but also any accessories, options, supplies or drugs which are related to the item and which are provided by the supplier. There should be a narrative description for each related item billed on a separate claim line. The exact HCPCS descriptor is not required; a reasonable, abbreviated descriptor may be substituted.

- For every item listed, the supplier must specify its submitted charge. For purchased equipment, accessories and options, the full charge must be specified. For rental equipment, accessories and options, the supplier must specify “per month” or “/ month.” For accessories, supplies, nutrients or drugs which are replaced regularly, the supplier must specify what time span the charge represents - e.g., per day, per week, per month, etc.

- The supplier must list the Medicare fee schedule amount for each item, accessory and option, if applicable. The fee schedule allowance should reflect the same time span and quantity used in the submitted charge column. If the Medicare allowed amount is determined by methods other than a fee schedule (e.g., for drugs, parenteral and enteral nutrients, PEN supplies, miscellaneous codes, etc.), an N/A (not applicable) should be written in the Medicare allowed charge column.

Samples of Section C formats are given in Examples 1 and 2 on page 96-240. Suppliers may use other formats as long as the required information is presented.

At this time, with form 484 for Home Oxygen Therapy, suppliers will not be required to list their submitted charges and Medicare fee schedule allowances on a separate sheet. HCFA will be initiating revisions to the 484 which will contain a Section C similar to forms 841-853. When this revision is complete, and the form has been cleared by the Office of Management and Budget (OMB), suppliers will be required to list submitted charges and fee schedule allowances.

Satisfactory completion of Section C will be assessed in post-payment audits. Civil monetary penalties can be assessed for failure to comply.

**Section D**

Section D contains the physician’s attestation statement, physician’s signature, and date. Claims submitted with CMNs lacking a physician signature will be denied. Suppliers billing electronically must indicate presence of the physician’s signature in the usual way.

**Filing Claims**

Camera ready copies of HCFA forms 841-853 begin on page 96-242. The CMN sent to the physician must be a two-sided CMN with instructions on the back. Because these forms have been approved by the OMB, when a CMN is submitted with a paper claim, the hard copy CMN must be an **EXACT** reproduction of the HCFA form. However, when the CMN is submitted electronically, the font on the hard copy CMN which the supplier retains in its files may be modified as follows:

- Pitch may vary from 10 characters per inch (cpi) to 17.7 cpi.
- Line spacing must be 6 lines per inch.
- Each CMN must have a minimum \( \frac{1}{4} \) inch margin on all four sides.
Without exception, these modified hard copy forms must contain questions and wording identical to the HCFA forms, in the same sequence with the same pagination and identical instructions and definitions printed on the back. CMN question sets may not be combined.

The original CMN must be retained in the supplier's file and be available to the DMERC on request. When CMNs are submitted with paper claims, the supplier must include a copy of only the front side(s). When CMNs are submitted electronically, only information from sections A, B and D is required.

**CMNs As Physician Orders**
The CMN can serve as the physician order if the narrative description is sufficiently detailed. This description would include quantities needed and frequency of replacement for accessories, supplies, nutrients and drugs.

For items requiring a written order on hand prior to delivery (air fluidized beds, TENS, POVs, seat lift mechanisms, etc.), suppliers may use a completed, physician-signed CMN; otherwise, a separate order, in addition to a subsequently completed and signed CMN, would be necessary.

**Cover Letter Guidelines**
The Social Security Act was amended in 1994 to specify the types of information suppliers may provide to physicians in a CMN. These types are limited to:

- an identification of the supplier and beneficiary,
- a description of the equipment and supplies being ordered, procedure codes for the equipment and supplies, and
- other administrative information not related to the medical condition of the patient.

It is **not** HCFA's or the DMERC's intent to restrict necessary communication between the supplier and the physician. Cover letters can be used as a way for suppliers to communicate with physicians. The information contained in the cover letters should address issues relating to HCFA or carrier regulation/policy changes, brief descriptions of the item(s) being provided and changes in the patient regimen.

It **is** HCFA's intent to prohibit suppliers from inappropriately influencing the physician's order or instructing the physician regarding what is medically necessary. While suppliers may verify the physician's original order, they may not change the substance of the physician's order or other information furnished by the physician, or add durable medical equipment, prosthetics, orthotics or supply (DMEPOS) items without explicit, documented instructions from the physician. The DMERCs may request to review the information provided in cover letters to ensure a supplier is in compliance with the law.

Providing answers to questions on CMNs or unilaterally changing any aspect of the physician's description of the patient's diagnosis would be considered violation of the statute.

The following are examples of the types of information appropriate to include in cover letters:

- Explanations of the sections of the form the physician must complete (e.g., "complete sections B and D") and/or specific questions the physician must answer;
- Where to send the CMN when they have completed it and how soon they need to do this;
- A copy of test results or report (e.g., blood gas report, wheelchair evaluation, discharge summary, nurses notes, etc.) obtained from a hospital, laboratory, outpatient facility, etc.; and
- A direct quote from the Medicare policy (e.g., "A wheelchair is covered if the patient's condition is such that without the use of a wheelchair he/she would otherwise be bed or chair confined").
Section C of the CMN was designed not only to provide the physician with charge information, but also to function as a confirmation of the physician's order. However, if suppliers wish to duplicate physician order information in a cover letter, they should feel free to do so.

### HCPCS Requiring A CMN Or DIF

These codes require a CMN/DIF and should be listed in Section A of the CMN/DIF. The description of related additional items also must be listed in Section C of HCFA forms 841-853. For narrative descriptions, refer to the HCPCS Section of your DMEPOS Supplier Manual.

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SECTION C EXAMPLES

Example 1

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<tr>
<td>A</td>
<td>K0004</td>
<td>High strength, lightweight wheelchair.</td>
<td>$110.31/month</td>
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<td>B</td>
<td>K0195</td>
<td>Elevating leg rests, pair.</td>
<td>$ 9.95/month</td>
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<tr>
<td>C</td>
<td>K0028</td>
<td>Fully reclining back.</td>
<td>$407.60</td>
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<tr>
<td>D</td>
<td>K0025</td>
<td>Hook-on headrest extension.</td>
<td>$56.90</td>
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<td>E</td>
<td>K0020</td>
<td>Fixed, adjustable height armrests, pair.</td>
<td>$40.82</td>
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Example 2

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<td>Ambulatory infusion pump</td>
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<td>B</td>
<td>K0111</td>
<td>Supplies for external drug infusion pump, per cassette or bag.</td>
<td>$121.44/week</td>
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<tr>
<td>C</td>
<td>K0110</td>
<td>Supplies for maintenance of drug infusion catheter, per week.</td>
<td>$20.39/week</td>
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<td>D</td>
<td>J2270</td>
<td>Morphine Sulfate, 10 mg.</td>
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* Medicare payment will be determined by a method other than a fee schedule. N/A does NOT indicate Medicare will deny the item.
SECTION A
Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(____) ____ ____ ____ ____ HICN

(____) ____ ____ ____ ____ NSC #

PLACE OF SERVICE

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB ____/____/____; Sex ___(M/F); HT.______(in.); WT._____(lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: ______________________________

PHYSICIAN'S TELEPHONE #:  (____) ____ ____ ____

SECTION B
Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): __________

ANSWERS ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS

(Circle Y for Yes, N for No, or D for Does Not Apply)

Y N D 1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?

Y N D 3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?

Y N D 4. Does the patient 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 aspiration?

Y N D 5. Does the patient require traction which can only be attached to a hospital bed?

Y N D 6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?

Y N D 7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: ____________________________________________ TITLE: ________________________ EMPLOYER: _________________________

SECTION C
Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

SECTION D
Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form, I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ______________________________ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A:  (May be completed by the supplier)

CERTIFICATION TYPE/DATE:  
If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked “INITIAL.” If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “REVISED.” If this is a recertification, indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “RECERTIFICATION.” Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the initial date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION:  
Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION:  
Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE:  
Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME:  
If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES:  
List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX:  
Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS:  
Indicate the physician's name and complete mailing address.

UPIN:  
Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO:  
Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B:  (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED:  
Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:  
In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:  
This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling “Y” for yes, “N” for no, “D” for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS:  
If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C:  (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST:  
Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/accessory/supply/drug, if applicable.

SECTION D:  (To be completed by the physician)

PHYSICIAN ATTESTATION:  
The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE:  
After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.
CERTIFICATE OF MEDICAL NECESSITY

SECTION A
Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(______) _______ - _______ HICN

(______) _______ - _______ NSC #

PLACE OF SERVICE ____________
NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB ____/____/____; Sex __ (M/F); HT.______(in.); WT._____(lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: ______________________________

PHYSICIAN'S TELEPHONE #: (______) _______ - _______

SECTION B
Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): __________ __________ __________ __________

ANSWERS ANSWER QUESTIONS 12, 13 & 21 FOR ALTERNATING PRESSURE PADS OR MATTRESSES; 13-22 FOR AIR FLUIDIZED BEDS

(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)

QUESTIONS 1-11, 17 AND 18 ARE RESERVED FOR OTHER OR FUTURE USE.

Y N D 12. Is the patient highly susceptible to decubitus ulcers?

Y N D 13. Are you supervising the use of the device?

Y N D 14. Does the patient have coexisting pulmonary disease?

Y N D 15. Has a conservative treatment program been tried without success?

Y N D 16. Was a comprehensive assessment performed after failure of conservative treatment?

Y N D 19. Are open, moist dressings used for the treatment of the patient?

Y N D 20. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?

21. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.

Pressure Ulcer Ulcer # 1 Ulcer # 2 Ulcer # 3

Stage: __________ __________ __________

Max. Length (cm): __________ __________ __________

Max. Width (cm): __________ __________ __________

1 2 3 22. Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: ________________________________________ TITLE: __________________________ EMPLOYER: _______________________

SECTION C
Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

SECTION D
Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ______________________________ DATE _____/_____/______ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A:  (May be completed by the supplier)

CERTIFICATION TYPE/DATE:  If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also, indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also, indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED OR RECERTIFICATION date.

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FACILITY NAME:  If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES:  List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

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PHYSICIAN NAME, ADDRESS:  Indicate the physician's name and complete mailing address.

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PHYSICIAN'S TELEPHONE NO:  Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

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EST. LENGTH OF NEED:  Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES:  In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION:  This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS:  If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C:  (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST:  Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D:  (To be completed by the physician)

PHYSICIAN ATTESTATION:  The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE:  After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.
# Certificate of Medical Necessity: Motorized Wheelchairs

**SECTION A**

**Certification Type/Date:**
- INITIAL ___/___/___
- REVISED ___/___/___

**PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER**

**SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER**

<table>
<thead>
<tr>
<th>PLACE OF SERVICE</th>
<th><strong>HCPCS CODE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PT DOB ____/____/____; Sex ____ (M/F); HT.______(in.); WT._____(lbs.)**

**PHYSICIAN NAME, ADDRESS (Printed or Typed)**

**PHYSICIAN’S UPIN:**

**PHYSICIAN’S TELEPHONE #:**

**SECTION B**

**Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

**EST. LENGTH OF NEED (# OF MONTHS):**

**DIAGNOSIS CODES (ICD-9):**

<table>
<thead>
<tr>
<th>ITEM ADDRESSED</th>
<th>ANSWERS</th>
<th>ANSWER QUESTIONS 1-4 FOR MOTORIZED WHEELCHAIR BASE, 4-18 FOR WHEELCHAIR OPTIONS/ACCESSORIES.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motorized Whlchr Base</td>
<td>Y</td>
<td>1. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?</td>
</tr>
<tr>
<td>Motorized Whlchr Base</td>
<td>Y</td>
<td>2. Have all types of manual wheelchairs been considered and ruled out?</td>
</tr>
<tr>
<td>Motorized Whlchr Base and Accessories</td>
<td>Y</td>
<td>4. Does the patient require and use a wheelchair to move around in their residence?</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y</td>
<td>5. Does the patient have quadriplegia?</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y</td>
<td>6. Does the patient have a fixed hip angle?</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y</td>
<td>7. Does the patient have a trunk cast or brace that requires a reclining back feature for positioning?</td>
</tr>
<tr>
<td>Elevating Leg Rest</td>
<td>Y</td>
<td>8. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating leg rest?</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y</td>
<td>10. Does the patient have excessive extensor tone of the trunk muscles?</td>
</tr>
<tr>
<td>Adjustable Height Armrest</td>
<td>Y</td>
<td>15. Does the patient have a need for arm height different than that available using non-adjustable arms?</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y</td>
<td>16. Does the patient need to rest in a recumbent position two or more times during the day?</td>
</tr>
<tr>
<td>Reclining Back: Adjustable HT. Armrest</td>
<td></td>
<td>18. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)</td>
</tr>
</tbody>
</table>

**NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):**

**NAME:**

**TITLE:**

**EMPLOYER:**

---

**U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES FORM APPROVED**

**HEALTH CARE FINANCING ADMINISTRATION OMB NO. 0938-0679**

**CERTIFICATE OF MEDICAL NECESSITY DMERC 02.02A**

**PAGE 1 OF 2**

---
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE:
If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient’s changing clinical needs), indicate the initial date needed in the space marked "INITIAL." and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient’s date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician’s name and complete mailing address.

UPIN: Accurately indicate the ordering physician’s Unique Physician Identification Number (UPIN).

PHYSICIAN’S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

ITEM ADDRESSED COLUMN: This references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.
SECTION C  Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

SECTION D  Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN’S SIGNATURE ________________________________  DATE _____/_____/_____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM HCFA 843 (4/96)
SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST:
Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier’s charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION:
The physician’s signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE:
After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician’s signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.
# Certificate of Medical Necessity

## Manual Wheelchairs

### SECTION A

**Certification Type/Date:** INITIAL ___/___/___        REVISED ___/___/___

**Patient Name, Address, Telephone and HIC Number**

<table>
<thead>
<tr>
<th>____)  __  -  ____  HICN</th>
</tr>
</thead>
</table>

**Supplier Name, Address, Telephone and NSC Number**

<table>
<thead>
<tr>
<th>____)  __  -  ____  NSC #</th>
</tr>
</thead>
</table>

**Place of Service**

**HCPCS Code**

**PT DOB ____/____/____;   Sex ____ (M/F);    HT.______(in.);    WT._____ (lbs.)**

**Name and Address of Facility if applicable (See Reverse)**

**Physician Name, Address (Printed or Typed)**

**Physician's UPIN:** ______________________________

**Physician's Telephone #:  (__ __ __) __ __ __- __ __ __ __**

### SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

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

**Diagnosis Codes (ICD-9):** _________   _________   _________   _________

<table>
<thead>
<tr>
<th>ITEM ADDRESSED</th>
<th>ANSWERS</th>
<th>ANSWER QUESTIONS 4 AND 18-22 FOR MANUAL WHEELCHAIR BASE; 4-18 FOR WHEELCHAIR OPTIONS/ACCESSORIES.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Whlchr Base And All Accessories</td>
<td>Y N D</td>
<td>(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted) Questions 1 - 3, 9, 11 - 14, 17, 19, and 21 reserved for other or future use.</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y N D</td>
<td>4. Does the patient require and use a wheelchair to move around in their residence?</td>
</tr>
<tr>
<td>Reclining Back</td>
<td>Y N D</td>
<td>5. Does the patient have quadriplegia?</td>
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<td>Y N D</td>
<td>6. Does the patient have a fixed hip angle?</td>
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<td>Y N D</td>
<td>15. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)</td>
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<tr>
<td>Any Type Ltwt. Whlchr</td>
<td>Y N D</td>
<td>18. If the answer to question #20 is &quot;No&quot;, would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?</td>
</tr>
</tbody>
</table>

**Name of Person Answering Section B Questions, If Other Than Physician (Please Print):**

**Name:** ________________________________________    **Title:** ____________________________    **Employer:** ____________________________
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATA: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked “INITIAL.” If this is a revised certification (to be completed when the physician changes the order, based on the patient’s changing clinical needs), indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “REVISED.” If this is a recertification, indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “RECERTIFICATION.” Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

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SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling “Y” for yes, “N” for no, “D” for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

ITEM ADDRESSED COLUMN: This references the equipment being addressed by each question. It is intended to be educational for the ordering physician.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.
SECTION C  Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered;  (2) Supplier’s charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option.  (See Instructions On Back)

SECTION D  Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ________________________________ DATE _____/_____/_____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.
# Continuous Positive Airway Pressure (CPAP) Certificate of Medical Necessity

## Section A

<table>
<thead>
<tr>
<th>Certification Type/Date:</th>
<th>INITIAL <em><strong>/</strong></em>/___</th>
<th>REVISED <em><strong>/</strong></em>/___</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient Name, Address, Telephone and HIC Number</th>
<th>Supplier Name, Address, Telephone and NSC Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>(___ ) ___ - ___ ___ HICN</td>
<td>(___ ) ___ - ___ ___ NSC #</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Place of Service</th>
<th>HCPCS Code</th>
<th>PT DOB <em><strong>/</strong></em>/____</th>
<th>Sex (M/F)</th>
<th>HT (in)</th>
<th>WT (lbs)</th>
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</thead>
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<table>
<thead>
<tr>
<th>Name and Address of Facility if applicable (See Reverse)</th>
<th>Physician Name, Address (Printed or Typed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHYSICIAN’S UPIN: ____________________________</td>
</tr>
<tr>
<td></td>
<td>PHYSICIAN’S TELEPHONE #: (___ ___) ___ ___ ___</td>
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</tbody>
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## Section B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

<table>
<thead>
<tr>
<th>Estimated Length of Need (# of Months):</th>
<th>1-99 (99=Lifetime)</th>
<th>Diagnosis Codes (ICD-9):</th>
<th>______</th>
<th>______</th>
<th>______</th>
<th>______</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Answers</th>
<th>Answer Questions 12 and 14 for CPAP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)</td>
</tr>
</tbody>
</table>

|        | Questions 1 - 11, and 13, reserved for other or future use. |
|        | 12. How many episodes of apnea lasting greater than 10 seconds does the patient have during 6-7 hours of recorded sleep? (Number of episodes) (If greater than 99, enter 99.) |
|        | 14. Does the patient have obstructive sleep apnea? |

<table>
<thead>
<tr>
<th>Name of Person Answering Section B Questions, If Other Than Physician (Please Print):</th>
<th>Name: ____________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Title: __________________________________________</td>
</tr>
<tr>
<td></td>
<td>Employer: ________________________________________</td>
</tr>
</tbody>
</table>

## Section C

Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier’s charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

## Section D

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician’s Signature: ____________________________ Date: ___/___/___

(Signature and Date Stamps Are Not Acceptable)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the date initially needed in the space marked "INITIAL," and also, indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician's name and complete mailing address.

UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING QUESTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

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SECTION A
Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(_____) _____ - ___ HICN

(_____) _____ - ___ NSC #

PLACE OF SERVICE __________

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB ____/____/____; Sex ___ (M/F); HT. ______(in.); WT. ______(lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: ______________________________

PHYSICIAN'S TELEPHONE #: (_____) ____ __ __- ___ __ __

SECTION B
Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): _________   _________   _________   _________

ANSWERS ANSWER QUESTIONS 7-11 FOR LYMPHEDEMA PUMP

(Circle Y for Yes, N for No, or D for Does Not Apply)

QUESTIONS 1 - 6, reserved for other or future use.

Y N D 7. Has the physician prescribed the pressures to be used and the frequency and duration of use of this device?

Y N D 8. Is the device prescribed for the treatment of chronic venous insufficiency with edema and/or venous ulcers?

Y N D 9. Has the patient had surgery or radiation that interrupted normal lymphatic drainage or is there a congenital abnormality of lymphatic drainage?

Y N D 10. Is there intractable lymphedema?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME:  ____________________________________________    TITLE:  ________________________     EMPLOYER:  _________________________

SECTION C
Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier’s charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

SECTION D
Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN’S SIGNATURE  ________________________________  DATE  _____/_____/_____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

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SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

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# Certificate of Medical Necessity

**OSTEOGENESIS STIMULATOR**

## SECTION A

<table>
<thead>
<tr>
<th>Certification Type/Date:</th>
<th>INITIAL <em><strong>/</strong></em>/___        REVISED <em><strong>/</strong></em>/___</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER</td>
<td>SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLACE OF SERVICE</th>
<th>HCPCS CODE</th>
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</thead>
<tbody>
<tr>
<td>NAME and ADDRESS of FACILITY if applicable (See Reverse)</td>
<td>PT DOB <strong><strong>/</strong></strong>/<strong><strong>; Sex ____ (M/F); HT.</strong>____(in.); WT.</strong>___(lbs.)</td>
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</table>

## SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

<table>
<thead>
<tr>
<th>EST. LENGTH OF NEED (# OF MONTHS):</th>
<th>DIAGNOSIS CODES (ICD-9):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-99 (99=LIFETIME)</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

**ANSWERS**

**ANSWER QUESTIONS 12-15 FOR OSTEOGENESIS STIMULATOR.**

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>(Circle <strong>Y</strong> for Yes, <strong>N</strong> for No, or <strong>D</strong> for Does Not Apply, Unless Otherwise Noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Does the patient have a non-union of a long-bone fracture?</td>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>13. Does the patient have a failed fusion?</td>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>14. Does the patient have a congenital pseudoarthrosis?</td>
<td><strong>Y</strong></td>
</tr>
<tr>
<td>15. How many months ago did the patient sustain the long-bone fracture being treated or have the fusion that has failed? (Enter number of months 1-99)</td>
<td>__________________</td>
</tr>
</tbody>
</table>

**NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):**

| NAME: | ____________________________ |
| TITLE: | ________________________ |
| EMPLOYER: | _________________________ |

## SECTION C

**Narrative Description Of Equipment And Cost**

1. Narrative, description of all items, accessories and options ordered; 2. Supplier's charge; and 3. Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

## SECTION D

**Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ____________________________ DATE _____/_____/______ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

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FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

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DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

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SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

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**SECTION A**

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<th>REVISED <em><strong>/</strong></em>/___</th>
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</thead>
</table>

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(_____) _____ - _____ HICN

(_____) _____ - _____ NSC #

PLACE OF SERVICE

NAME and ADDRESS of FACILITY if applicable (See Reverse)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: ______________________________

PHYSICIAN'S TELEPHONE #:  (__ __ __) __ __ __- __ __ __ __

**SECTION B**

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

| EST. LENGTH OF NEED (# OF MONTHS): | 1 - 99 (99=LIFETIME) | DIAGNOSIS CODES (ICD-9): | [ ]
|------------------------------------|----------------------|--------------------------|

**ANSWERS**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>D</th>
<th>ANSWER QUESTIONS</th>
<th>1 - 6 FOR RENTAL OF TENS, AND 3 - 12 FOR PURCHASE OF TENS.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)</td>
<td></td>
</tr>
</tbody>
</table>

1. Does the patient have acute post-operative pain?

2. What is the date of surgery resulting in acute post-operative pain?

3. Does the patient have chronic, intractable pain?

4. How long has the patient had intractable pain? (Enter number of months, 1 - 99.)

5. Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number)

   - Headache
   - Visceral abdominal pain
   - Pelvic pain
   - Temporomandibular joint (TMJ) pain
   - None of the above

6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?

7. Has the patient received a TENS trial?

8. What are the dates that trial of TENS unit began and ended?

9. What is the date that you reevaluated the patient at the end of the trial period?

10. How often has the patient been using the TENS? (Circle appropriate number)

    1 = Daily
    2 = 3 to 6 days per week
    3 = 2 or less days per week

11. Do you and the patient agree that there has been a significant improvement in the pain and that long term use of a TENS is warranted?

12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time:

    2 = 2 leads
    4 = 4 leads

**SECTION C**

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

**SECTION D**

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE ______________________________

DATE _____/_____/_____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL." and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL." and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician's name and complete mailing address.

UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26884, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.
### FORM HCFA 849 (4/96)

**SECTION A**

**Certification Type/Date:**
- INITIAL ___/___/___
- REVISED ___/___/___

**PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER**
- (______) ____-______ HICN

**SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER**
- (______) ____-______ NSC #

**PLACE OF SERVICE**
- ________

**HCPCS CODE**
- ________

**PT DOB ____/____/____; Sex ____ (M/F); HT.______(in.); WT._____(lbs.)**

**NAME and ADDRESS of FACILITY if applicable (See Reverse)**
- ________

**PHYSICIAN NAME, ADDRESS**
- (Printed or Typed)

**PHYSICIAN'S UPIN:**
- ______________________________

**PHYSICIAN'S TELEPHONE #:**
- (______) ____-______

### SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

**EST. LENGTH OF NEED (# OF MONTHS):**
- 1-99 (99=LIFETIME)

**DIAGNOSIS CODES (ICD-9):**
- _________   _________   _________   _________

**ANSWERS**

1. Does the patient have severe arthritis of the hip or knee?  
2. Does the patient have a severe neuromuscular disease?  
3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?  
4. Once standing, does the patient have the ability to ambulate?  
5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

**NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):**
- NAME:  ____________________________________________
- TITLE:  ________________________
- EMPLOYER:  _________________________

### SECTION C

**Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered;  (2) Supplier's charge; and  (3) Medicare Fee Schedule Allowance for each item, accessory, and option.  (See Instructions On Back)

### SECTION D

**Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

**PHYSICIAN'S SIGNATURE**
- ________________________________

**DATE**
- _____/_____/_____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician's name and complete mailing address.

UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item, option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.
# Certificate of Medical Necessity

**Section A**

<table>
<thead>
<tr>
<th>Certification Type/Date:</th>
<th>INITIAL <em><strong>/</strong></em>/___</th>
<th>REVISED <em><strong>/</strong></em>/___</th>
</tr>
</thead>
</table>

**Patient Name, Address, Telephone and HIC Number**

(Patient Information)

**Supplier Name, Address, Telephone and NSC Number**

(Supplier Information)

**Place of Service**

(Suppliers) **HCPCS Code**

**Birth Date (PT DOB) ____/____/____; Sex ____ (M/F); HT.______(in.); WT._____(lbs.)**

**Physician Name, Address**

(Printed or Typed)

**Physician's UPIN:** ______________________________

**Physician's Telephone #:  (__ __ __) __ __ __- __ __ __ __**

**Section B**

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

**Estimated Length of Need (# of Months):** 1-99 (99=LIFETIME)

**Diagnosis Codes (ICD-9):**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answer</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Y</td>
<td>Does the patient require a POV to move around in their residence?</td>
</tr>
<tr>
<td>7.</td>
<td>Y</td>
<td>Have all types of manual wheelchairs (including lightweight) been considered and ruled out?</td>
</tr>
<tr>
<td>8.</td>
<td>Y</td>
<td>Does the patient require a POV only for movement outside their residence?</td>
</tr>
<tr>
<td>12.</td>
<td>Y</td>
<td>Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?</td>
</tr>
<tr>
<td>13.</td>
<td>Y</td>
<td>Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?</td>
</tr>
<tr>
<td>14.</td>
<td>Y</td>
<td>Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?</td>
</tr>
</tbody>
</table>

**Name of Person Answering Section B Questions, If Other Than Physician (Print):**

**Name:** __________________________________________

**Title:** ________________________

**Employer:** _________________________

**Section C**

Narrative Description Of Equipment And Cost

1. Narrative description of all items, accessories and options ordered;
2. Supplier's charge; and
3. Medicare Fee Schedule Allowance for each item, accessory, and option. (*See Instructions On Back*)

**Section D**

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

**Physician’s Signature** ______________________________

**Date** ____/____/_____ (Signature and Date Stamps are Not Acceptable)

**Form HCFA 850 (4/96)**
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL; "and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL; and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

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PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item, option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

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**EXTERNAL INFUSION PUMP**

**SECTION A**

<table>
<thead>
<tr>
<th>Certification Type/Date:</th>
<th>INITIAL</th>
<th>REVISED</th>
</tr>
</thead>
</table>

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HICN</td>
<td>NSC #</td>
</tr>
</tbody>
</table>

PLACE OF SERVICE

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB / ; Sex (M/F) ; HT. (in.) ; WT. (lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN:

PHYSICIAN'S TELEPHONE #: 

**SECTION B**

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

**EST. LENGTH OF NEED (# OF MONTHS):** 1-99 (99=LIFETIME)

**DIAGNOSIS CODES (ICD-9):**

ANSWERS  ANSWER QUESTIONS 1 - 7 FOR EXTERNAL INFUSION PUMP.

(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)

1 3 4

1. Circle number of pump which has been prescribed:
   1 - External infusion pump (non-disposable);
   2 - Reserved for other or future use;
   3 - Implantable infusion pump;
   4 - Disposable infusion pump (e.g., elastomeric)

HCPCS CODE: 

2. Provide the HCPCS code for the drug that requires the use of the pump.

3. If non-specific code was used to answer questions, print name of drug.

1 3 4

4. Circle number for route of administration?
   1 - Intravenous;
   2 - Reserved for other or future use;
   3 - Epidural;
   4 - Subcutaneous

1 2 3

5. Circle number for method of administration? 1 - Continuous;
   2 - Intermittent;
   3 - Bolus

6. What is the total duration of drug infusion per 24 hours? (1 - 24)

Y N D

7. Does the patient have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME: 

TITLE: 

EMPLOYER: 

**SECTION C**

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

**SECTION D**

Physician Attestation and Signature/Date

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PHYSICIAN'S SIGNATURE 

DATE / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL." If this is a recertification, indicate the initial date needed in the space marked "REVISED." If this is a recertification, indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

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SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

NAME OF PERSON ANSWERING SECTION B QUESTIONS: If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

SECTION C: (To be completed by the supplier)

NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN ATTESTATION: The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.
**SECTION A**

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(____) __ __ __ - __ __ __ __ HICN __________________________

(____) __ __ __ - __ __ __ __ NSC # _______________________

PLACE OF SERVICE ________

HCPCS CODE

PT DOB ____/____/____; Sex ____ (M/F); HT.______(in.); WT.____(lbs.)

NAME and ADDRESS of FACILITY if applicable (See Reverse)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: ______________________________

PHYSICIAN'S TELEPHONE #: (____) __ __ __- __ __ __ __

**SECTION B**

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): _________   _________   _________   _________

ANSWERS ANSWER QUESTIONS 1, AND 3 - 5 FOR PARENTERAL NUTRITION

(Circle Y for Yes, N for No, or D for Does Not Apply, Unless Otherwise Noted)

Question 2 reserved for other or future use.

Y       N 1. Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?

_____ 3. Days per week infused? (Enter 1 - 7).

4. Formula components:

   Amino Acid (ml/day) _____ concentration % _____ gms protein/day

   Dextrose (ml/day) _____ concentration %

   Lipids (ml/day) _____ days/week _____ concentration %

5. Circle the number for the route of administration. 2, 4, 5, 6 - Reserved for other or future use.

1 - Central Line;  3 - Hemodialysis Access Line;  7 - Peripherally Inserted Catheter (PIC)

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):

NAME:  ____________________________________________    TITLE:  ________________________     EMPLOYER:  _________________________

**SECTION C**

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

**SECTION D**

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE  ________________________________  DATE  _____/_____/_____

(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)
SECTION A: (May be completed by the supplier)

CERTIFICATION TYPE/DATE: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked “INITIAL.” If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “REVISED.” If this is a recertification, indicate the initial date needed in the space marked “INITIAL,” and also indicate the recertification date in the space marked “RECERTIFICATION.” Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

PATIENT INFORMATION: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

SUPPLIER INFORMATION: Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).

PLACE OF SERVICE: Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.

FACILITY NAME: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS CODES: List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.

PATIENT DOB, HEIGHT, WEIGHT AND SEX: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

PHYSICIAN NAME, ADDRESS: Indicate the physician's name and complete mailing address.

UPIN: Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).

PHYSICIAN'S TELEPHONE NO: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

SECTION B: (May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.

DIAGNOSIS CODES: In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).

QUESTION SECTION: This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling “Y” for yes, “N” for no, “D” for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.

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NARRATIVE DESCRIPTION OF EQUIPMENT & COST: Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.

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PHYSICIAN SIGNATURE AND DATE: After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

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**SECTION A**
Certification Type/Date: INITIAL ___/___/___     REVISED ___/___/___     RECERTIFICATION ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

PLACE OF SERVICE ________

NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB ____/____/____;   Sex ____ (M/F) ;    HT.______(in.) ;    WT._____(lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: ______________________________

PHYSICIAN'S TELEPHONE #:  (__ __ __) __ __ __- __ __ __ __

**SECTION B**
Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

<table>
<thead>
<tr>
<th>EST. LENGTH OF NEED (# OF MONTHS):</th>
<th>______ 1-99 (99=LIFETIME)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIAGNOSIS CODES (ICD-9):</td>
<td>_______ _______ _______ _______</td>
</tr>
</tbody>
</table>

**ANSWERS**

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>ANSWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?</td>
</tr>
<tr>
<td>8.</td>
<td>Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient’s overall health status?</td>
</tr>
<tr>
<td>10.</td>
<td>Print product name(s).</td>
</tr>
<tr>
<td>11.</td>
<td>Calories per day for each product?</td>
</tr>
<tr>
<td>12.</td>
<td>Days per week administered? (Enter 1 - 7)</td>
</tr>
<tr>
<td>13.</td>
<td>Circle the number for method of administration?</td>
</tr>
<tr>
<td>14.</td>
<td>Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?</td>
</tr>
<tr>
<td>15.</td>
<td>Additional information when required by policy:</td>
</tr>
</tbody>
</table>

**SECTION C**
Narrative Description Of Equipment And Cost

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### Ombudsmen Addresses and Their Territories

**Sharon Briggman**
P.O. Box 97424  
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8200 S. Quebec St.  
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Englewood, CO  80112  
(303) 683-4309

**Vince Temples**
P.O. Box 767337  
Roswell, GA  30076  
(770) 663-7644

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**To Be Announced**

In the interim please contact:
Pam Mayhak  
P.O. Box 100141  
Columbia, SC  29202-3141  
(803) 735-1034, Ext. 37207

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Florida is covered by two ombudsmen.

**Keith Smith** covers the northern portion of Florida (includes Pinellas, Hillsborough, Polk, Osceola and Brevard counties, and all points north).

**Teresita Ortiz** covers the southern portion of Florida (includes Manatee, Hardee, Highlands, Okeechobee and Indian River counties, and all points south).

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Ombudsmen are those who investigate complaints, report findings and help achieve equitable settlements through training and education of the supplier community.