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Certificate of Medical Necessity for Incontinence Supplies, Page 1 of 2

Recipient Name: _____	Ordering Provider's Name: _____
Medicaid #: _____	Medicaid ID # or NPI: _____
Date of Birth: _____ Age: ____ Sex: _____ (M or F)	Telephone #: (____) _____ Ext. _____
HT: _____ (inches) WT: _____ (pounds) Date of last visit: _____	Prescription Start Date: _____ Retrospective Review? _____ (Y/N)

SECTION A: CLINICAL INFORMATION

*This section **must** be completed by the attending physician, physician assistant, or nurse practitioner.*

DIAGNOSIS	ICD-9-CM

Estimated Length of Need (# of Months): _____ 1-99 (99=Lifetime)

SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEMS(S) AND PLAN

Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. *This section may be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.*

Plan: The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.

Daily Usage Supplies (circle appropriate quantity):

Disposable brief/ undergarment: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ Other qty _____*

Insert pads (used in briefs): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ Other qty _____*

Disposable bed pads: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ Other qty _____*

** 1 unit = one container (bottle, tube, etc.) regardless of size or volume

***Note to supplier: If the packaging quantity is not the same as the 100/200/300/400/500 quantity circled, you may round to the nearest size packaging to avoid breaking open a package

Monthly Usage Supplies (circle appropriate quantity):

Reusable Bed Pads w/ or w/out flaps: ○ 1 ○ 2 ○ 3 ○ 4 ○ Other qty _____*

Gloves (per month): ○ 100 ○ 200 ○ 300 ○ 400 ○ Other qty _____*

** Moisture Barrier Ointment/Gel: ○ 1 ○ 2 ○ 3 ○ 4 ○ Other qty _____*

** Moisture Barrier Cream: ○ 1 ○ 2 ○ 3 ○ 4 ○ Other qty _____*

** Moisture Barrier Lotion: ○ 1 ○ 2 ○ 3 ○ 4 ○ Other qty _____*

** Protectant Powder: ○ 1 ○ 2 ○ 3 ○ 4 ○ Other qty _____*

** Skin Cleanser: ○ 1 ○ 2 ○ 3 ○ 4 ○ Other qty _____*

***Disposable wipes (each): ○ 100 ○ 200 ○ 300 ○ 400 ○ 500 ○ Other qty _____*

***Disposable wash cloths (each): ○ 100 ○ 200 ○ 300 ○ 400 ○ 500 ○ Other qty _____*

* If "other quantity" is completed, you must provide additional medical justification for the higher quantity requested.

Please note: These supplies are for incontinence treatment only and not for treatment of other areas of the body.

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

_____ Signature of Provider – Title

_____ Date

I hereby certify that I am the ordering physician, physician assistant, or nurse practitioner identified in this form above.