SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ **Medicaid # (10 digits)** _____

(2) DOB ____/____/____ **Sex:** ___ **HT:** _____**(in) WT:** _____**Date of Service:** _____

(3) Provider's name: _____ **Provider's DME #:** _____ **NPI#:** _____

(4) Street address: _____**City:** _____ **State:** _____ **Zip:** _____**Local telephone #:**_____

(5) Provider's signature: _____**Date:** _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: _____

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING /ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD): _____ **Diagnosis(s):** _____

_____ _____

(8) Indicate the patient's mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):

_____

_____

- **Explain why a cane or walker is not sufficient to meet the patient's mobility needs in the home:**

_____

- **Explain why a manual wheelchair is not sufficient to meet the patient's mobility needs in the home:**

_____

- **How long has the condition been present and what is the patient's clinical progression:**

_____

_____

- **Indicate any related diagnosis and all other interventions tried and the results:**

_____

_____

- **Has the patient ever used a walker, manual or power wheelchair and what were the results?**

_____

_____

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____
(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____

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

(12) PRINT PHYSICIAN'S NAME: _____ PHYSICIAN'S NPI #_____

PHYSICIAN'S SIGNATURE: _____ DATE ____/____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD diagnosis code(s).**
QUESTION SECTION:	**This information is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 90 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 90 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame may be returned (if submitted with a PA) or rejected (if attached with a claim submission) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**