Certificate of Medical Necessity (CMN) - Generic - Fee For Service

Beneficiary Medicaid ID #:_____ **DOB:**_____

Beneficiary Full Name:_____ **Height**_____ **Weight**_____**(lbs)**

Ordering Prescriber Medicaid ID #_____ **Phone:**_____

Prescriber Full Name:_____ **FAX:**_____

Provider Medicaid ID #: _____ **Phone:**

Provider Name: _____ **FAX:**_____

Nurse Practitioners (NP)/Physician Assistants (PA) Only – *must complete*

Collaborating Physician's NPI #:_____ **Collaborating Physician's MS Medicaid #:**_____

MEDICAL INFORMATION

Timing (circle one)
Prospective
Concurrent
Retrospective

Medical Diagnosis (specific ICD CM code):			
Primary:		Secondary:	

Description of Items requested	CPT Code		Date of Service(s)	Modifier if Applicable

Provider Attestation, Signature and Date
I certify that the items listed on this form are the exact items offered and certified as medically necessary by the ordering, prescribing provider whose signature appears on this form, and these exact items will be delivered to the beneficiary listed on this form. I will not knowingly present or cause to be presented false or fraudulent information, including presenting information with deliberate ignorance or reckless disregard for its truth or falsity. Further, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and authorize DOM to verify this information. I understand that any omission, misrepresentation, or falsification of any information presented in any application for Medicaid benefits or Medicaid payments may be punishable by criminal, civil, or other administrative actions. A false attestation may result in civil monetary penalties, as well as fines, and may disqualify the provider from participation in the Medicaid program.

Provider Representative (print full name) _____

Provider Representative Signature:_____ **Date:** _____

Prescriber Attestation, Signature and Date
I, a physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed services, will not knowingly present or cause to be presented false or fraudulent information, including presenting information with deliberate ignorance or reckless disregard for its truth or falsity. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in Section A of this form. I certify that the medical necessity information in Section B is true, correct, and complete to the best of my knowledge, and authorize DOM to verify this information. I certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission, misrepresentation, or concealment of any information presented in any application for Medicaid benefits or Medicaid payments may be punishable by criminal, civil, or other administrative actions. A false attestation may result in civil monetary penalties, as well as fines, and may disqualify me from participation in the Medicaid program.

Prescribing Provider Name (please print full name) _____

Prescribing Provider Signature:_____ **Date:** _____
Prescribing provider's signature (stamped signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

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Instructions:

The CMN Must Contain:

1. Beneficiary's Mississippi Medicaid Identification number, Date of Birth (DOB) and Beneficiary full name.
2. Prescribing Providers Mississippi Medicaid Identification number, full name, FAX and current telephone number.
3. Provider's Mississippi Medicaid Identification number, Provider's name (business name) current FAX number and telephone number.
4. The beneficiary's diagnoses along with associated ICD-10 code(s)
5. Item(s) description, associated CPT code(s), initial request or new, requested dates of service, modifier if applicable.
6. Physician/Nurse Practitioner/Physician Assistant Order if needed or required. The CMN can serve as the physician's detailed written order if the narrative description in section C is sufficiently detailed. This would include initial or new request addressed, CPT code, dates of service, and modifier, if applicable.
7. The CMN must include the prescribing provider's signature and the date of the signature. Signature stamps, date stamps, or the signature of anyone other than the provider is not acceptable.