Certificate of Medical Necessity (CMN)

Physical, Occupational, and/or Speech Therapy – Fee For Service

Section I: Beneficiary and Provider Information

Beneficiary Medicaid ID#: _____ DOB:

Beneficiary Full Name: _____

Ordering MD/NP/PA Medicaid ID#: _____ Phone: _____

Ordering MD/NP/PA Full Name: _____ Fax: _____

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

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

Section II: Clinical Information

Date of Last visit: _____

ICD Code	Diagnosis Description

Clinical Summary: Indicate relative history demonstrating patient's need for each requested therapy service (physical, occupational, and/or speech therapy).

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Ordering MD/NP/PA Orders:

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Section III: Ordering MD/NP/PA 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 I on this form. I certify that the medical necessity information in Section II 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 services requested in Section II of this form and that I deem them medically necessary for the patient listed in Section I. 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.

Ordering MD/NP/PA Printed Name and Title: _____

Ordering MD/NP/PA Signature: _____ **Date:** _____