Telligen **Certificate of Medical Necessity (CMN) – Incontinence Supplies – 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 Practitioner (NP)/Physician Assistant (PA) Only – **MUST COMPLETE**

Collaborating Physician NPI #:	
Collaborating Physician MS Medicaid #:	

Section C: MEDICAL INFORMATION

Medical Diagnosis (specific ICD CM code):	Initial Revised
Primary:	
Secondary:	
Physician Order Narrative	

Description of items requested	CPT Code	Date of Service(s)	**Modifier,** if applicable

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Description of items requested	**CPT Code**	**Date of Service(s)**	**Modifier,** if applicable

Patient Mobility: (check all that apply)

Is beneficiary able to control bowel or bladder function	YES		NO	
Is beneficiary able to use regular toilet facilities	YES		NO	
Is beneficiary able to transfer from bed to chair/wheelchair without assistance	YES		NO	
Is beneficiary able to physically turn or reposition themselves	YES		NO	

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 (Print Full Name): _____

Prescribing Provider Signature: _____ **Date:** _____

Stamped signatures and date stamps, or the signature of anyone other than the provider, are not acceptable.

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INSTRUCTIONS

The CMN **must include** the following:

1. **Beneficiary Information**
   - Mississippi Medicaid Identification Number
   - Date of Birth (DOB)
   - Full name

2. **Prescribing Provider Information**
   - Mississippi Medicaid Identification Number
   - Full name
   - Fax number
   - Current telephone number

3. **Provider (Supplying Entity) Information**
   - Mississippi Medicaid Identification Number
   - Business name
   - Current fax number
   - Telephone number

4. **Medical Information**
   - Beneficiary's diagnoses, including associated ICD-10 code(s)

5. **Complete List of Requested Items and Services**
   - Description of item(s)
   - Associated CPT code(s)
   - Indicate if it is an initial or new request
   - Requested dates of service
   - Modifier(s), if applicable

6. **Physician/Practitioner Order (if required)**
   - If needed, an order must be included from a Physician, Nurse Practitioner, or Physician Assistant.
   - The CMN may serve as the detailed written order **if** Section C contains a complete narrative description. This must include:
     - CPT code
     - Dates of service
     - Modifier(s), if applicable
     - Note whether the request is initial or new

7. **Signature Requirements**
   - The CMN must be signed and dated by the prescribing provider.
   - Stamped signatures, date stamps, or signatures by anyone other than the provider are not acceptable.