Telligen®

Patient Name: _____ DOB: _____

CERTIFICATION OF MEDICAL NECESSITY FOR COMPLEX REHAB AND CUSTOM DURABLE MEDICAL EQUIPMENT

PT/OT Evaluation are required. This form can be used for: Wheelchairs, Bath Chairs, Gait Training, Standing Frames, Specialty Walkers, Sit-to-Stand Systems

Primary Diagnosis		**Procedure Code**	
Secondary Diagnosis		**Procedure Code**	
Length of Need			

Certification Type ☐ Initial ☐ Revised							**Date** / /	
Beneficiary Name:					**Beneficiary Medicaid Number** (Do Not Use Mother's ID):			
Patient DOB	/ /	**Sex**		**HT**		(in)	**WT**	(lbs)
Supplier Name:					**Supplier Address and Telephone Number:**			
Supplier NPI Number:								
Physician Name:					**Physician Address and Telephone Number:**			
Physician NPI Number:								

HCPCS Code(s)	
Place of Service	

Telligen®

Patient Name: _____ DOB: _____

PHYSICAL EXAMINATION

Provide detailed results for the physical examination as it relates to the beneficiary's mobility needs, and any related needs for special accommodation, options or accessories.

Ambulatory Status	Is the beneficiary ambulatory? ☐YES ☐ NO If yes, describe in detail:
Endurance	Describe the beneficiary's level of endurance:
Neck and Head Control	Describe the beneficiary's ability to control their head and neck:
Truck	Provide review of exam of the beneficiary's trunk:
Pelvis/Hips	Provide review of exam of the beneficiary's pelvis/hips:

Patient Name: _____ DOB: _____

Upper Extremities	Provide review of exam of the beneficiary's upper extremities:
Skin Integrity	Provide review of exam of beneficiary's skin integrity:

ACTIVITIES

Describe the activities of daily living and associated environments in which the complex or custom equipment is required for use:

☐ Home (required for in-home ambulation) Percentage of time required _____

☐ School (beneficiary is enrolled in school either in-home or in the community

Enrolled at _____ Hours per Day _____

☐ Community Use (school, physician visits, etc.) ☐ Other _____

Does the beneficiary have complex or custom equipment to this request issued during the following time frame?

a) The last 5 years for beneficiary over 21? ☐ Yes ☐ No

b) The last 3-5 years for beneficiary under 21? ☐ Yes ☐ No

EQUIPMENT ORDERED

Describe the specific **modifications, options, and accessories** that are most appropriate for this beneficiary and provide detailed rationale:

Patient Name: _____ DOB: _____

HCPCS	MODIFICATIONS, OPTIONS, ACCESSORIES

Rationale:

_____

_____

_____

_____

_____

Ordering Physician

I certify that the complex or custom durable medical equipment listed on this certificate is medically necessary for this beneficiary, and that I have had a face-to-face evaluation with this beneficiary to discuss and review the appropriateness of the device within the six (6) months preceding this order, and I am enrolled with Mississippi Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face _____ *Must have occurred within 180 days prior to the order date.*

Physician's Signature _____ Date _____

Patient Name: _____ DOB: _____

Physical or Occupational Therapist (PT/OT)

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature _____ Date _____

PT/OT License Number _____ Expiration Date _____

Licensed DME Supplier

The ATP certified member who completed the assessment for this beneficiary and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

ATP Member Signature _____ Date _____

Printed Name of ATP Member _____

License/Certification # _____ Expiration Date _____

Attach a copy of license or certification with prior authorization request.