Telligen®

Patient Name: _____DOB: _____

CERTIFICATION OF MEDICAL NECESSITY FOR CUSTOM DURABLE MEDICAL EQUIPMENT

PT/OT EVALUATION REQUIRED

(To include, but not limited to: WHEELCHAIRS, BATH CHAIRS, GAIT TRAINERS, STANDING FRAMES, SPECIALTY WALKERS, SIT-TO-STAND SYSTEMS, ECT.)

Certification Type/Date: INITIAL _____/_____/_____ REVISED ____/_____/____	
Members Name: _____	**Members Medicaid Number (Do Not List Mother's ID):** _____
Patient DOB_____/_____/_____ Sex_____HT._____(in) WT._____(lbs.)	
Suppliers Name: _____ **Suppliers NPI Number:** _____	Suppliers Address and Telephone Number: _____ _____ _____
Physicians' Name: _____ **Physicians NPI Number:**	Physicians Address and Telephone Number: _____ _____ _____
HCPCS Code(s)	
Place of Service	

Primary Diagnosis _____ICD-10 Diagnosis Code _____

Secondary Diagnoses supporting medical necessity: _____

_____ ICD 10 Diagnosis Code(s) Length of Need_____

_____

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PHYSICAL EXAMINATION:

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

Ambulatory Status	Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail:
Endurance	Describe the members' level of endurance:
Neck and Head Control	Describe the member's ability to control their head and neck:
Trunk	Provide review of exam of the member's trunk:
Pelvis/Hips	Hips Provide review of exam of the member's pelvis/hips:
Upper Extremities:	Provide review of exam of the member's upper extremities:
Skin Integrity	Provide review of exam of member's skin integrity:

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 (member's enrolled in school either in-home or in the community):

Enrolled at _____Hours per Day_____

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

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

a) The last 5 years for members over 21? ☐ YES ☐ NO

b) The last 3-5 years for members under 21? ☐ YES ☐ NO

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EQUIPMENT ORDERED

Please provide the HCPCS code and the description of the item determined to be the most appropriate for the member in the tables below. Provide a detailed rationale of why this equipment was selected and why any available least costly alternative was not deemed appropriate, where one exists.

HCPCS	BASE	Quantity Needed

Describe the specific custom equipment that is most appropriate for this member and provide a detailed rational:

_____

_____

_____

_____

_____

HCPCS	MODIFICATIONS, OPTIONS, ACCESSORIES	QUANTITY

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

_____

_____

_____

_____

_____

Ordering Physician

I certify that the complex or custom durable medical equipment listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member 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 evaluation _____/_____/_____ (Must have occurred

within 180 days prior to the order date) Physician's Signature_____

_____Date__/_____/_____

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 Printed Name _____

PT/OT GA License Number _____Expiration Date____/_____/_____

Licensed DME Supplier

The NRRTS Member who completed the assessed this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature _____Date_____/_____/_____

Printed Name of NRRTS Member _____

License/Certification # _____Expiration Date ____/_____/_____

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

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Mississippi Medicaid.