Telligen

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 Practitioner (NP)/Physician Assistant (PA) Only – **MUST COMPLETE**

Collaborating Physician NPI #:	
Collaborating Physician MS Medicaid #:	

MEDICAL INFORMATION

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

Description of items requested	HCPC Code	Order Date	Expected Length of Need	Modifier, if applicable	Quantity

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 participating 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.