

# **CERTIFICATE OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT (DME) (EXCEPT WHEELCHAIRS AND SCOOTERS)**

*The provider must complete all applicable areas not completed by the clinician or therapist.*

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

***Incomplete information will result in a deferral, denial or delay in payment of the claim.***

## REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

### SECTION 1—Clinician's Information:

Clinician Name (Print)	Last	First	Phone Number (    )	License Number
Address	Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: \_\_\_\_\_

### SECTION 2—Patient's Information: New Rx (For Rx Renewal, please also complete 2A below)

Patient Name (Print)	Last	First	Phone Number (    )	Date of Birth mm / dd / yy	Medi-Cal Number
Address	Street	City	State	ZIP	

Date of last face-to-face visit with the beneficiary: \_\_\_\_\_

Is this beneficiary expected to be institutionalized within the next 10 months?    Yes ☐ No ☐ Explain "Yes" answer: \_\_\_\_\_

Equipment required for:

- ☐ Less than 10 months (code the TAR for a rental)
- ☐ More than 10 months (code the TAR for a purchase)

### SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

### SECTION 3—Equipment Requested:

- a) \_\_\_\_\_
- b) STANDARD: \_\_\_\_\_ BARIATRIC: \_\_\_\_\_
- c) Replacing existing equipment?    Yes ☐ No ☐ If yes, explain why: \_\_\_\_\_
- d) Attach repair estimate if replacement with similar equipment is requested.
- e) Other DME the beneficiary has: \_\_\_\_\_
- f) How many hours per day of usage? \_\_\_\_\_
- g) Accessories requested and why: \_\_\_\_\_
- h) Custom features requested and why: \_\_\_\_\_
- i) Other equipment currently in the home:    Cane ☐ Walker ☐ Crutches ☐ Prosthesis ☐ Manual Wheelchair ☐  
       Power Wheelchair ☐ Hospital Bed ☐ Oxygen ☐ POV (scooter) ☐ Other: \_\_\_\_\_
- j) Patient currently using the following equipment: \_\_\_\_\_
- k) When/How often: \_\_\_\_\_
- l) State specific reason for accessories requested: \_\_\_\_\_

**SECTION 4—Diagnosis Information**

Diagnoses: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Prognosis: \_\_\_\_\_

**SECTION 5—Pertinent History:****SECTION 6—Functional Status:**

Beneficiary's height: \_\_\_\_\_

Beneficiary's weight: \_\_\_\_\_

- a) Ambulation: Independent ☐ Walker/Cane ☐ Assisted ☐ Unassisted ☐ Unable ☐ Bed confined ☐  
 Recent fall(s) ☐ Dizziness/Vertigo ☐ Incoordination ☐ Ataxia ☐ Severe shortness of breath ☐
- b) Transfer: Self ☐ Self, but with great difficulty ☐ Self with a transfer device ☐  
 Stand by assistant ☐ With assistance ☐ Mechanical or person lift ☐

c) Pertinent physical findings: Edema (location): \_\_\_\_\_

Pressure sore(s), state and location: Amputee ☐ Cast ☐ Ataxia ☐

Paralysis/weakness (location): \_\_\_\_\_ Sitting Posture/Deformity: \_\_\_\_\_

Cognitive status: \_\_\_\_\_ Vision: Impaired ☐ Normal ☐

Contractures: \_\_\_\_\_

**SECTION 7—Living Environment:**House/condominium ☐ Apartment ☐ Stairs ☐ Elevator ☐ Ramp ☐ Hills ☐ SNF ☐ ICF/DD ☐ B&C ☐

Other: \_\_\_\_\_

Living Assistance: Lives alone ☐ With other person(s) ☐ Alone most of the day ☐ Alone at night ☐Attendant care: Live in attendant ☐ or \_\_\_\_\_ Hours/day Homemaker ☐ Hours \_\_\_\_\_

Transportation: \_\_\_\_\_

**SECTION 8—Hospital Bed:**

Document that this beneficiary requires positioning not feasible in an ordinary bed: \_\_\_\_\_

Is frequent repositioning required throughout the day? Yes ☐ No ☐ Explain: \_\_\_\_\_Is frequent repositioning required throughout the night? Yes ☐ No ☐Can the beneficiary or caretaker use a "manual" bed? Yes ☐ No ☐


If no, explain why: \_\_\_\_\_

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

**SECTION 9—DME provider/Therapist attestation and signature/date:**

*By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.*


Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print): \_\_\_\_\_

Name: \_\_\_\_\_  
(Please print)Title: \_\_\_\_\_  
(OT, PT, RESNA, etc.)DME Provider Name: \_\_\_\_\_  
(Please print)
 \_\_\_\_\_  
(Use Ink - A signature stamp is not acceptable)

 \_\_\_\_\_  
(Use Ink - A signature stamp is not acceptable)
**SECTION 10—Clinician attestation and signature/date:**

*I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.*

Clinician's Signature: \_\_\_\_\_

 \_\_\_\_\_ Date: \_\_\_\_\_  
(Use Ink - A signature stamp is not acceptable)