

Certificate of Medical Necessity for Incontinence Supplies



MEMBER INFORMATION	PROVIDER INFORMATION
Member Name: _____ <i>(Last, First, MI)</i>	Ordering Provider's Name: _____
Alaska Medicaid Member ID: _____	Provider Medicaid ID or NPI: _____
Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____	Phone Number: _____ Ext. _____
*Height: _____ (inches) *Weight: _____ (pounds)	Prescription Start Date: _____
Date of last visit: _____	Retrospective Review? Yes No

SECTION A - CLINICAL INFORMATION *(This section MUST be completed by the attending physician, physician assistant, or nurse practitioner.)*

	Diagnosis Code	Diagnosis Description
ICD-10		

Estimated Length of Need (# of Months): _____ *(99 = Lifetime)*

SECTION B - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN

Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Attach any supporting documentation as needed for further justification. *(This section may be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.)*

PLAN: *The plan should list each service or item specifically needed for the treatment of the member. Additional treatment information may be attached to this form.*

<p>Daily Usage Supplies <i>(mark appropriate quantity):</i></p> <p>Disposable Brief / Undergarment Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4 5 6 7 8</p> <p>Insert Pads <i>(used in briefs)</i> Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4 5 6 7 8</p> <p>Disposable Bed Pads Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4 5</p> <p><small>* If "Other Qty" is completed, you must provide additional medical justification for the higher quantity requested.</small></p> <p><small>** 1 Unit = One container <i>(bottle, tube, etc.)</i> regardless of size or volume.</small></p> <p><small>*** Note to Supplier: If the packaging quantity is not the same as the 100/200/300/400/500 quantity circled, you may round to the nearest size packaging to avoid breaking open a package.</small></p>	<p>Monthly Usage Supplies <i>(mark appropriate quantity):</i></p> <p>Reusable Bed Pads w/ or w/o Flaps Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4</p> <p>Gloves <i>(per month)</i> Other Qty _____*</p> <p style="padding-left: 40px;">100 200 300 400</p> <p>Moisture Barrier Ointment/Gel** Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4</p> <p>Moisture Barrier Cream** Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4</p> <p>Moisture Barrier Lotion** Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4</p> <p>Protectant Powder** Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4</p> <p>Skin Cleanser** Other Qty _____*</p> <p style="padding-left: 40px;">1 2 3 4</p> <p>Disposable Wipes <i>(each)</i>*** Other Qty _____*</p> <p style="padding-left: 40px;">100 200 300 400 500</p> <p>Disposable Wash Cloths <i>(each)</i>*** Other Qty _____*</p> <p style="padding-left: 40px;">100 200 300 400 500</p>
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NOTE: These supplies are for incontinence treatment only and not for treatment of other areas of the body.

ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN/ PHYSICIAN ASSISTANT/NURSE PRACTITIONER

A physician, physician assistant, or nurse practitioner who attests to the medical necessity and quantity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws, and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

I hereby certify that I am the ordering physician, physician assistant, or nurse practitioner identified in this form.

Signature of Physician / Physician Assistant / Nurse Practitioner	Date
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