Sample/Example CMN

CERTIFICATE OF MEDICAL NECESSITY

Speech Generating Device (SGD)

SECTION A **Certification Type/Date: INITIAL / /**

PATIENT NAME, ADDRESS, TELEPHONE and Medical ID NUMBER MEDICAL ID NUMBER:		SUPPLIER NAME, ADDRESS, and TELEPHONE NUMBER Sample Company 1022 Sample Address City, ST Zip Code Phone Number
PLACE OF SERVICE: NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE	PATIENT DOB [ ] SEX: FEMALE ☐ MALE ☐ PHYSICIAN NAME, ADDRESS, TELEPHONE and NPI NUMBER ( ) - NPI Date of physician's face to face examination of patient for the SGD: [ ]

SECTION B **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MTHS) **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):**

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1-6 FOR SGD, OPTIONS/ACCESSORIES; 7 FOR repairs, 8 for UPGRADE/REPLACEMENT. (**Y** for **Yes, N** for **No, D** for **Does not apply** (unless otherwise noted)
SGD and All Accessories	Y☐ N☐ D☐	1. Has the patient had a formal evaluation of cognitive and language ability by a SLP with no financial connection to supplier and a copy of the evaluation submitted to the treating physician?
	Y☐ N☐ D☐	2. Does the patient have a medical condition resulting in a severe expressive speech disability?
	Y☐ N☐ D☐	3. Can the patient's speaking needs be met using natural communication methods?
	Y☐ N☐ D☐	4. Have other forms of treatment been considered and ruled out?
	Y☐ N☐ D☐	5. Will the patient's speech disability benefit from the device?
Accessories	Y☐ N☐ D☐	6. Has the medical necessity for each accessory been documented in the formal evaluation?
Repairs	Y☐ N☐ D☐	7. Does the patient have continued medical need for the device/accessory for which the repairs are requested?
Upgrade/Replacement	Y☐ N☐ D☐	8. Does the upgrade/replacement provide enhanced features or other improvements?

NAME OF PERSON ANSWERING SECTION B QUESTION, IF OTHER THAN PHYSICIAN :
NAME: TITLE: EMPLOYER:

SECTION C **Narrative Description of Equipment and Cost**

☐ CHECK HERE IF ADDITIONAL OPTONS/ACCESSORIES ARE LISTED ON BACK.

SECTION D **Physician Attestation and Signature/Date**

I, _____[print full name of physician], hereby attest that the medical record entry listed above accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.] when I treated/diagnosed the above listed patient in a face to face encounter. I attest that the device is medically necessary for the patient's health. If submitting electronic signatures on medical records, I attest that I used my own ID and password to enter the system to sign the medical records and any prescription. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.
PHYSICIAN'S SIGNATURE MUST BE LEGIBLE; SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.

_____

PHYSICIAN'S SIGNATURE **DATE**

Physician/Hospital Footer Information

SECTION A:	**(May be completed by the supplier.)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her medical ID number as it appears on his/her medical card.
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 32, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB AND SEX:	Indicate the patient's date of birth (MM/DD/YY) and sex (male or female).
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address **plus date of most recent appointment with the patient**.
NPI:	Accurately indicate the ordering physician's National Provider Identification Number (NPI).
PHYSICIAN'S TELEPHONE:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed and the CMN signed (In Section D) by the ordering physician.)**
ESTIMATED LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99. ****This field must be completed.**
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, selecting "Y" for yes, "Y" for no, and "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., SLP) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier.)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs, and the supplier's charge for each item, option, accessory, and/or supply.
SECTION D:	**(To be completed by the physician.)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C, and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Physician/Hospital Footer Information