Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
Compression Garments

Instructions: The Certificate of Medical Necessity (CMN) must be used for compression garments under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Recipient	Billing Number

Street Address	City/State/Zip	Date of Birth

Section A – Must be completed by Physician

Diagnosis(es)

- ☐ Elephantiasis
- ☐ Milroy's Disease
- ☐ Orthostatic hypertension
- ☐ Stasis dermatitis
- ☐ Stasis ulcers
- ☐ Symptomatic chronic venous insufficiency
- ☐ Pregnancy with associated chronic venous insufficiency
- ☐ Lymphedema
- ☐ Thrombophlebitis
- ☐ Post-thrombotic syndrome
- ☐ Other, explain:

Compression Garments

Brand Name _____

Hg mm Compression of Product ____

Specify the garments ordered for this patient ___

_____

_____

_____

I custom, explain ___

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MANUFACTURER'S PRICE LIST AND THE GARMENT CATALOGUE NUMBER MUST BE ATTACHED

Section B – Physician Attestation and Signature/Date

Physician Name (printed)

I certify that I am the prescriber identified above. I certify that the information in Section B of this certificate of medical necessity and any information on any attached documents signed and dated by me, is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician Signature	Date	Prescriber's NPI Number
		Prescriber's Medicaid Legacy Number