Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION

GENERAL MEDICAL SUPPLIES: OVERAGE

Instructions: This Certificate of Medical Necessity / Prescription (CMN/Rx) must be used for Medical Supplies requiring Prior Authorization or for quantities in excess of an established allowable under the Ohio Medicaid Program. This form must be completed and carry the proper signature(s), where indicated. For requests to be considered for prior authorization, this form must be used in conjunction with Form JFS 03142.

Consumer Name	Billing Number

Date of Birth	Height / Weight	Attachments:	
		☐ Price List/Invoice ☐ Other	☐ Initial Certification ☐ Recertification(Prev PA# _____) ☐ Change (PA # _____)

Section A - Medical Necessity Information

Diagnosis(es) - include ICD-9 codes and description:	☐ Testing Supplies - Type & # Tests per day ☐ Surgical Supplies - Type & # Procedures per day ☐ Ostomy/Urological Supplies - Type & # Procedures

Item Code	Name of Item	Total Units Required Per Day / Week / Month (indicate frequency)	Item Provided as (e.g.; ea, roll, pkg, yd, etc.) & # Units in each	Item Supplied as (e.g.; bx, ctn, cs, etc.) & # Items in each	Total Units / Other Codes Billed Direct	Total Overage Units Requested

Description of Tests / Procedures, Special Considerations, and Rationale for Overage/Quantities Requested:

Start Date	**End Date**

Section B - Completion Attestation and Signature/Date

Name of Person Completing Form, if not prescriber (with credentials if applicable) (PRINTED)

I certify that I am the individual identified above. I certify that the information I have completed in 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.

Signature (No Stamps)	Date	Employer	License #

Section C - Prescriber Attestation and Signature/Date

Prescriber Name (PRINTED)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is 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

Prescriber Signature (No Stamps)	Date	Ohio Medicaid Provider #