Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION

DECUBITUS CARE EQUIPMENT (PRESSURE REDUCING SUPPORT SURFACES)

Instructions: The Certificate of Medical Necessity (CMN) must be used for all approved pressure reducing support surfaces 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 Consumer	Provider NPI#	
Consumer Medicaid #	Provider Medicaid Legacy # (Optional)	
Consumer Address	City/State/Zip	Date of Birth

Section A - Must be completed by Prescriber

Diagnosis(es) with ICD-9 code (Mandatory) and optional description

☐ Yes ☐ No Skin grafts/flaps? If yes, date of surgery	☐ Yes ☐ No Burns, 3rd degree? If yes, date	If yes, describe burns

Prescriber order for pressure-reducing support surface. Specify product make/model (Prescription may be attached to this form in lieu of completing this item)

NOTE: If requesting approval for 30-day coverage post flap/graft surgery, completion of the remainder of section A is NOT REQUIRED.

Number of requested days	Prescriber ordered wound treatment protocol (Prescription may be attached in lieu of completing this section of the form)
Date of initial placement of patient on surface	

Note: Date of order(s) must be written within 30 days of prior authorization (PA) submission or placement of consumer on the surface.

Lab Reports (current within 21 days of PA submission or placement of consumer on surface. May be attached to this form)

Albumin	Date	Pre-Albumin	Date	Tot. Protein	Date	Hbg.	Date	HCT	Date

Wound Description—excluding extremities (Current within 21 days prior to PA submission or placement of patient on surface.)

	Date	Location	Appearance	Length	Width	Depth	Stage	Signature-Licensed Individual
1								
2								
3								
4								

Weight History—For at least 60 days prior to submission of PA request or placement on surface. Wound graph from chart may be submitted in lieu of completing this section of this form.	Date	Wt.	Date	Wt.	Date	Wt.	Date	Wt.

Section B - Prescriber Attestation and Signature/Date

Prescriber Name (PRINTED)	Prescriber NPI#

I certify that I am the prescriber identified above. I certify that the information in Section A of this certificate of medical necessity and any information on the attached documents signed and dated by me, are 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	Date	Prescriber Medicaid Legacy # (Optional)