

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
IPPV OR APAP IN LIEU OF A VOLUME VENTILATOR

Certification Type: <input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Recertification		
<i>Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators 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.</i>		
Name of consumer		Name of consumer Medicaid billing#
Street address	City/State/Zip	Date of birth
List other respiratory equipment in use		
Section A—Must be completed by prescriber		
Diagnosis(es) Include ICD-9 code and description		
Date of last examination by prescriber (must be within 30 days prior to first date of service)	Consumer has permanent tracheostomy <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical history (attach hospital discharge summary, if applicable)		
<input type="checkbox"/> APAP or <input type="checkbox"/> IPPV device is required for ventilatory support/only effective alternative to a volume ventilator		Length of need <input type="checkbox"/> Short term, # of months <input type="checkbox"/> Chronic/permanent
Ventilatory support requirements <input type="checkbox"/> Continuous <input type="checkbox"/> Nocturnal only <input type="checkbox"/> Other, explain:	Ventilator settings/parameters O2 setting	
Prescriber's name (PRINTED)		
<i>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.</i>		
Prescriber's signature	Date	Ohio Medicaid Legacy # NPI #
Section B—Must be completed by Licensed Respiratory Care Professional (LRCP)		
Complete this section if the ventilator was dispensed prior to submitting prior authorization request		
Licensed respiratory care professional services Date placed on ventilator <input type="checkbox"/> Yes <input type="checkbox"/> No Home evaluation prior to hospital discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No Home set up? <input type="checkbox"/> Yes <input type="checkbox"/> No In-home training provided to care givers? If "yes", check all that apply: <input type="checkbox"/> Ventilator operation <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Cleaning/sterilizing technique	Home visits first week <input type="checkbox"/> 5-7 <input type="checkbox"/> 3-4 <input type="checkbox"/> 1-2 Home visits after the first week (at least monthly) Dates: 1) 2) 3) 4) 5) 6) Is the consumer being weaned? <input type="checkbox"/> Yes <input type="checkbox"/> No	
LRCP name (PRINTED)		
<i>I certify that I am the respiratory therapist 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.</i>		
LRCP signature	Date	License #