

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY: VENTILATORS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation
Conditions for which ventilatory support is needed <input type="checkbox"/> Chronic respiratory failure <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Neuromuscular disease <input type="checkbox"/> A chronic pulmonary disorder <input type="checkbox"/> Another neurological disorder or thoracic restrictive disease _____ <input type="checkbox"/> This individual has undergone a permanent tracheostomy.	
Estimated length of need <input type="radio"/> _____ months <input type="radio"/> Indefinite/perpetual	Continuity of support required <input type="checkbox"/> Constant <input type="checkbox"/> During the day <input type="checkbox"/> At night <input type="checkbox"/> For sleep only <input type="checkbox"/> Other _____
Description of ventilator Type _____ Mode _____ Settings or parameters _____	
<input type="checkbox"/> Attached is documentation showing that this individual is being weaned.	
Other respiratory equipment in use <input type="checkbox"/> A secondary or back-up ventilator is necessary. <input type="checkbox"/> The individual cannot maintain spontaneous respiration for at least four hours. <input type="checkbox"/> Because of regular activities outside the home (e.g., school, outpatient therapy), the individual needs a second ventilator with a suitable power source. <input type="checkbox"/> The average emergency medical team response time to the individual's address is estimated to be more than two hours.	

Attestation [This section must be completed by the prescriber.]

<i>I hereby attest that the certification information above is true, correct, and complete.</i>	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.