Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
SUPPORT SURFACES

SECTION A **Certification Type/Date: INITIAL**___/____/____ **REVISED**____/____/____ **RECERTIFICATION**___/___/____		
PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER (__ __ __) __ __ __-__ __ __ __ MEMBER # _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER (__ __ __) __ __ __-__ __ __ __ NSC OR NPI # _____
PLACE OF SERVICE _____	HCPCS CODE	PT DOB ____/____/____ Sex _____ (M/F) Ht. ____(in) Wt. _____(lbs.)
NAME and ADDRESS of FACILITY *If applicable*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER (__ __ __) __ __ __-__ __ __ __ NSC OR NPI # _____

SECTION B Information in this Section **May Not Be** Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS); _____1-99 (99=LIFETIME)	DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____

ANSWERS	Circle Y for Yes, N for NO or D for Does not apply, unless otherwise noted.
Y N D	1. Is the patient highly susceptible to decubitus ulcers?
Y N D	2. Are you supervising the use of the device?
Y N D	3. Does the patient have coexisting pulmonary disease?
Y N D	4. Has a conservative treatment program been tried without success?
Y N D	5. Was a comprehensive assessment performed after failure of conservative treatment?
Y N D	6. Are open, moist dressings used for the treatment of the patient?
Y N D	7. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?
	8. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress, or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place "9" under ulcer #1.
1 2 3	9. Over the past month, the patient's ulcer(s) has/have: 1—Improved 2—Remained the same 3—Worsened?

Pressure Ulcer	Ulcer #1	Ulcer #2	Ulcer #3
Site:	_____	_____	_____
Stage:	_____	_____	_____
Max length (cm):	_____	_____	_____
Max width (cm:	_____	_____	_____
Depth (cm):	_____	_____	_____

To expedite timely review, medical records to support the above statement must be submitted at the time of request.

Name of person answering section B questions, if other than the physician (PLEASE PRINT):

Name_____Title_____Employer_____

SECTION C Narrative Description of Equipment and Cost.

(1) Narrative description of all items, accessories, and options ordered; (2) Supplier's charge.

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed, and signed by me. I certify that the medical necessity information in Section B is true, accurate, and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____DATE _____/_____/_____