

Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Parenteral Therapy		
Patient Name, Address, Telephone Number, and Date of Birth Medicaid ID Number _____	Physician Name, Address, and Telephone Number NPI Number _____	
Diagnosis	Height	Weight
Prognosis	Estimated Length of Need (Months) 1-99 (99=Lifetime)	
1. Description of functional impairment? <input type="checkbox"/> Malabsorption <input type="checkbox"/> Swallowing impairment <input type="checkbox"/> Hyper metabolic <input type="checkbox"/> Impaired consciousness <input type="checkbox"/> Nonfunctioning GI tract <input type="checkbox"/> Intestinal obstruction <input type="checkbox"/> Aspiration <input type="checkbox"/> Other _____ <input type="checkbox"/> Mental incapacity <input type="checkbox"/> Nausea/Vomiting		
2. Formula components? <input type="checkbox"/> Amino Acid _____ (ml/day) _____ concentration % _____ gms protein/day <input type="checkbox"/> Dextrose _____ (ml/day) _____ concentration % <input type="checkbox"/> Lipids _____ (ml/day) _____ days/week _____ concentration %		
3. Residence <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Hospital Rehab Unit <input type="checkbox"/> Institution <input type="checkbox"/> Group Home <input type="checkbox"/> Other _____		
4. Does the patient have severe, disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. How many days per week is the patient infused? (1-7) _____		
6. Route of administration <input type="checkbox"/> Central Line <input type="checkbox"/> Hemodialysis Access Line <input type="checkbox"/> Peripherally Inserted Catheter (PIC)		
7. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Narrative description of all items, accessories, options, and special additives ordered to include supply changes and amounts. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document). <input type="checkbox"/> Yes , additional attachments are included. <input type="checkbox"/> No , additional attachments are not included.		
I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.		
Signature and date stamps are not acceptable.		
_____ Physician's Signature		_____ Date (mm/dd/yyyy)