Medicaid

Montana Medicaid Certificate of Medical Necessity

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

Pressure Reducing Surfaces

Section A

Patient Name, Address, Telephone Number, and Date of Birth **Medicaid ID Number**_____	**Physician Name, Address, and Telephone Number** **NPI Number** _____

Diagnosis (List the stage, location, size, depth, and type of drainage for all pressure ulcers.)

Prognosis

Treatment Plan

Previous Treatment Plan

Date of Last Evaluation by Physician	**Physician's Name**

Section B

1. Can the patient reposition themselves? ☐ Yes ☐ No
2. Does patient have coexisting pulmonary disease? ☐ Yes ☐ No
3. Does the patient have a compromised circulation status? ☐ Yes ☐ No
4. Does the patient have fecal or urinary incontinence? ☐ Yes ☐ No
5. Is patient bedridden? ☐ Yes **If yes**, how many hours? _____ ☐ No
6. Does the patient have a nutritional plan? ☐ Yes ☐ No
7. Narrative description of **all** items, accessories, sizes, and options, including model numbers to be included in this section. 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).
   ☐ **Yes,** additional attachments **are** included**.** ☐ **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)**