State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

# CERTIFICATE OF MEDICAL NECESSITY

**SUPPORT SURFACES**

## SECTION A

**Certification Type/Date:** **INITIAL___/___/___** **REVISED___/___/___**

| PATIENT NAME, ADDRESS, TELEPHONE | SUPPLIER NAME, ADDRESS, TELEPHONE |
|---|---|
| (_____) _____- _____ | (_____)_____-_____ |

| PLACE OF SERVICE _____<br>NAME and ADDRESS of FACILITY if applicable (See Reverse) | HCPCS CODE:<br>_____<br>_____ | **PT DOB___/___/___; Sex_____(M/F) ; HT._____(in.) ; WT._____(lbs.)**<br>**PHYSICIAN NAME, ADDRESS (Printed or Typed)**<br>**PHYSICIAN'S UPIN:** _____ _____<br>**PHYSICIAN'S TELEPHONE #: (_____)_____- _____** |
|---|---|---|

## 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 | ANSWER QUESTIONS 1, 7 & 8 for Alternating Pressure Pads or Mattresses; 1-8 for Air Fluidized Beds. (Circle **Y** for Yes, **N** for No) |
|---|---|
| Y N | 1. Are you supervising the use of the device? |
| Y N | 2. Does the patient have coexisting pulmonary disease? |
| Y N | 3. Has a conservative treatment program been tried without success? |
| Y N | 4. Was a comprehensive assessment performed after failure of conservative treatment? |
| Y N | 5. Are open, moist dressings used for the treatment of the patient? |
| Y N | 6. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed? |
| | 7. 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 a "9" under ulcer #1. |
| 1 2 3 | 8. 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 |
|---|---|---|---|
| Stage: | _____ | _____ | _____ |
| Max. Length (cm): Max. | _____ | _____ | _____ |
| Width (cm): | _____ | _____ | _____ |

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME:_____TITLE:_____ EMPLOYER: _

## SECTION C

**Narrative Description Of Equipment**

**(1)** Narrative description of all items, accessories and options ordered;

## SECTION D

**Physician Attestation and Signature/Date**

I certify that I am the 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 ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)