



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

**Certificate of Medical Necessity for Durable Medical Equipment/Supplies**

**SECTION A: TO BE COMPLETED BY PROVIDER**

RECIPIENTS NAME: \_\_\_\_\_ Date: \_\_\_\_\_  
 Medical Assistance ID Number: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  
 DME Provider's Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_  
 DME Provider Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 ICD Type<sup>1</sup> / DX: ( ) \_\_\_\_\_ Description: \_\_\_\_\_  
 Print ordering Prescriber's name: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Procedure Code(s) \_\_\_\_\_

**SECTION B: TO BE COMPLETED OR REVIEWED AND SIGNED BY PRESCRIBER**

**Prognosis:** \_\_\_\_\_ **ICD Type<sup>1</sup> / DX:** ( ) \_\_\_\_\_

How long is this problem expected to last? \_\_\_\_\_ Months  
 Please enter number of months, 1-99 (99=Lifetime)

**Functional Level** Indicate recipient's ambulatory status while performing Activities of Daily Living:

- Non-ambulatory  Ambulatory, without assistance  
 Ambulatory with the aid of a walker or cane  Ambulatory, other assistance as described

**Equipment being prescribed**, including an explanation of purpose and use of item: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

For dressing supplies, please indicate the dressing change required per day, week, month, etc. \_\_\_\_\_  
 \_\_\_\_\_

Duration of need: \_\_\_\_\_ Months \_\_\_\_\_ Lifetime  
 Please indicate duration by months, not to exceed 12. If lifetime please indicate above.

Please indicate the date that the recipient was last seen: \_\_\_\_\_

**Prescriber Certification (must be signed and dated by prescriber)**

**I certify that the ordered DME and Supplies are part of my treatment plan, documented in medical record, and, in my opinion, are medically necessary.**

\_\_\_\_\_  
**Print Ordering Prescriber's Name**

\_\_\_\_\_  
**Prescriber Signature**

\_\_\_\_\_  
**Date**

<sup>1</sup> ICD TYPE VALUES ARE DEFINED AS FOLLOWS: 2 = ICD-9, 3 = ICD-10.