



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

RECIPIENT _____ Date _____
Medicaid ID number _____ Ht _____ Wt _____
DME Provider name _____
Street Address _____ City _____ State _____
DME Provider contact name _____ Phone _____
Print ordering Prescriber's name _____
Procedure Code(s) _____ NPI _____

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

Face-to-Face Visit Date (if applicable) _____

Diagnosis (DX) Code _____

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

Please indicate duration by months, not to exceed 12. A certificate of Medical Necessity (CMN) is valid for 12 months from the date of issue. After 12 months from the date of issue, a new CMN is required.

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