



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

CERTIFICATE OF MEDICAL NECESSITY

EXTERNAL INFUSION PUMP			
SECTION A Certification Date:			
PATIENT NAME, ADDRESS, TELEPHONE (____) ____-____		SUPPLIER NAME, ADDRESS, TELEPHONE (____) ____-____	
Date of last office visit: _____	HCPCS CODE: _____	PT DOB ____/____/____; Sex ____ (M/F); HT. ____ (in.); WT. ____ (lbs.) Prescriber's Name: Prescriber's Address: Prescriber's Telephone: NPI:	
SECTION B <i>Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.</i>			
EST. LENGTH OF NEED (# OF MONTHS): ____ 1-99 (99=LIFETIME)		Diagnosis Codes:	
ANSWERS	ANSWER QUESTIONS 1 through 5 (circle applicable number).		
1 2 3	1. Circle number of pump which has been prescribed: 1 - External infusion pump (non-disposable); 2 - Implantable infusion pump; 3 - Disposable infusion pump (e.g. elastomeric)		
HCPCS Code: _____	2. Provide the HCPCS code and description for the drug that requires the use of the pump. Description:		
_____	3. If a NOC (not otherwise classified) HCPCS Code is listed in Question 2, print name of drug.		
1 2 3	4. Circle a number for method for route of administration: 1 - Intravenous; 2 - Epidural; 3 - Subcutaneous		
	5. Circle a number for method of administration: 1 – Continuous; 2 – Intermittent; 3 - Bolus		
SECTION C Additional Comments			
SECTION D Prescriber's Signature/Date			
I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.			
PRESCRIBER'S SIGNATURE			Date: