# 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:**

#### SECTION B  
**Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

**EST. LENGTH OF NEED (# OF MONTHS):______**

**Diagnosis Codes:**

<table>
<thead>
<tr>
<th>ANSWERS</th>
<th>ANSWER QUESTIONS 1 through 5  (circle applicable number).</th>
</tr>
</thead>
</table>
| 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:  

05/15