Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY / REQUEST FOR NEED VERIFICATION
GENERAL MEDICAL SUPPLIES AND EQUIPMENT

Identifying Information *[This section may be completed by the supplier.]*

Individual			**Prescriber**	**Provider**
Given (first) name	Family (last) name		Name	Name
Medicaid ID number			Medicaid provider number	Medicaid provider number
Date of birth			NPI	NPI
Height *(inches)*	Weight *(lbs.)*	☐ Male ☐ Female	Telephone number ext.	
Street address*				
City	State	ZIP Code		

***Note:** *Provision of or payment for certain equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.*

Purpose

☐ Initial certification ☐ Change ☐ *[Optional]* Renewal/continuation Previous PA number _____

Attachments ☐ Price list ☐ Invoice ☐ Other _____

Medical Information *[This section may be transcribed by the provider.]*

Diagnosis code(s)

	HCPCS code	Description	Quantity requested		HCPCS code	Description	Quantity requested
1				11			
2				12			
3				13			
4				14			
5				15			
6				16			
7				17			
8				18			
9				19			
10				20			

Full explanation of why items should be authorized

Starting date for dispensing	Ending date

Attestation *[This section must be completed by the prescriber.]*

I hereby attest that the certification information above is true, correct, and complete.	
Signature	Date of signature

FALSE CERTIFICATION CONSTITUTES MEDICAID FRAUD.