Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: INCONTINENCE ITEMS

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

Individual			**Prescriber**	**Provider**
Name			Name	Name
Medicaid ID number			Medicaid provider number	Medicaid provider number
Date of birth			NPI	NPI
Height (in.)	Weight (lbs.)		Telephone number	Previous PA number *(if applicable)*
Address*			***Note:** Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.	
City	State	ZIP Code		

Purpose

Select ONE option. ☐ Initial certification ☐ Change ☐ Renewal/continuation *(if applicable)*

Certification [This section may be transcribed by the provider.]

Diagnosis code(s)	Date of assessment	Starting date for dispensing
Type of incontinence	Length of need ☐ months (<12) ☐ 12 months ☐ Lifetime	

Note: Payment cannot be made for items related to stress incontinence to which no specific physiological, psychological, or physiopsychological cause can be attributed.

Specific incontinence item *(with, e.g., HCPCS code or style/size)*	Quantity needed per month

Comments

Attestation [This section must be completed by the prescriber]

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

False certification constitutes Medicaid fraud.