Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: INSULIN PUMPS

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

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

Mark all items that apply.

Diagnosis code(s)	Date of face-to-face assessment

- ☐ The individual has type 1 or insulin-dependent type 2 diabetes mellitus.
- ☐ The individual has the following symptoms or conditions (marked when applicable):
  - ☐ Glycated hemoglobin level (HbA1c) greater than 7%
  - ☐ A history of recurring hypoglycemia
  - ☐ Wide fluctuations in blood glucose before mealtime
  - ☐ A marked early-morning increase in fasting blood sugar (the "dawn phenomenon")
  - ☐ A history of severe glycemic excursions
- ☐ The individual has completed a diabetes education program within the preceding twenty-four months.
- ☐ The individual has been on a maintenance program for at least six months involving at least three injections of insulin per day and frequent self-adjustments of insulin dosage.
- ☐ The individual has performed glucose self-testing at least four times per day on average during the preceding month.
- ☐ The individual is at high risk for preventable complications of diabetes.

Certification for Additional Rental or Purchase [This section may be transcribed by the provider.]

Mark all items that apply.

☐ Rental Requested dates from _____ to _____ Prior dates from _____ to _____ ☐ Purchase	Prior PA number

- ☐ The individual (or someone assisting the individual) is capable of managing the pump and that the desired improvement in metabolic control can be achieved.

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.