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
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
Height (in.) Weight (lbs.) Sex ○ F ○ M	Telephone number	
Address*	*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.	

Attachments: ☐ Price list ☐ Invoice ☐ Other ____

○ Initial certification
○ Recertification – Previous PA #_______________
○ Change – PA #_______________

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

Diagnosis code(s)

HCPCS code	Description	PA requirement / Limit (quantity per period)	Quantity requested

Full explanation of why each line item should be authorized

Starting date	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.

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