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	
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.	

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

Diagnosis code(s)	Date of assessment
Type of incontinence	Length of need, in months (≤ 12) [blank = 12]

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 garment or disposable supply	Quantity needed per month

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.