CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
PNEUMATIC COMPRESSION DEVICES AND ACCESSORIES

SECTION A: Consumer/Provider Information

Certification Type: ☐ **Initial** ☐ **Revised** ☐ **Recertification**			
Consumer's Name		Provider's Name	
Consumer DOB	Consumer Sex ☐ Female ☐ Male	Consumer HT (in.)	Consumer WT (lbs.)
(If consumer is not residing at home address) Facility Name		Prescriber's Name	
		Prescriber's NPI Number	
Facility Address		Prescriber's Telephone	
Facility City, State and Zip Code		Prescriber's Medicaid Legacy Number (Optional)	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months) 1-99 (99=**LIFETIME**)	Diagnosis Codes (ICD-9)

Last Consumer Medical Examination (MM/DD/YR):

ANSWERS	ANSWER QUESTIONS 1-5 FOR PNEUMATIC COMPRESSION DEVICES (Check **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted, please provide additional information on any **Y** responses in section (C) (2) of this form)
☐ Y ☐ N ☐ D	1. Does the consumer have chronic venous insufficiency with venous stasis ulcers?
☐ Y ☐ N ☐ D	2. If the consumer has venous stasis ulcers, have you seen the consumer regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?
☐ Y ☐ N ☐ D	3. Has the consumer had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?
☐ Y ☐ N ☐ D	4. Does the consumer have a malignant tumor with obstruction of the lymphatic drainage of an extremity?
☐ Y ☐ N ☐ D	5. Has the consumer had lymphedema since childhood or adolescence?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER *(Please Print)*

Name	Title	Employer

SECTION C: Narrative Description of Equipment, Cost and Medical Necessity

(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for each item, accessory, and option.

(2) Narrative description of all **Y** answers reflected in section **B** of this document and any additional clinical information necessary to support medical necessity of equipment and accessories being prescribed.

I certify that I am the prescriber identified above. I certify that the information on this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

Prescriber's Signature	
Date	Provider's NPI Number