CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
REPAIR OF DURABLE MEDICAL EQUIPMENT (DME)

SECTION A: Consumer/Provider Information

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

SECTION B: Item Description/Repair Description

Name and description of Item being repaired (**Include any make or model numbers)**	Diagnosis Codes (ICD-9) of Consumer	(ICD-9) Descriptions of Consumer (Optional)
Last Consumer Medical Examination (MM/DD/YR)		
Age of current equipment		
Description of the current nature of the damage, wear, etc		
Description of required parts needed to complete repair (**Include part numbers and codes)**		
Description, Dates and Location of any previous repairs of this equipment		
Existing Warranty ☐ **YES** ☐ **NO** **DATE OF WARRANTY EXPIRATION** (MM/DD/YR)		
Breakdown of the estimated charges for the repairs to make this equipment serviceable (**Include Labor charges)**		

ODJFS takes into consideration the age of the equipment, which should not be less than the useful lifetime of the equipment, and the breakdown of the repair charges necessary to make the equipment serviceable. The repair estimates should be compared to the Medicaid fee schedule OAC rule 5101:3-1-60, Appendix DD for the purchase price of the piece of equipment being repaired to determine if repair is justified.

Repair cases suggesting malicious damage, culpable neglect or wrongful disposition of equipment will require additional information to be submitted to ODJFS for review. In cases where ODJFS determines that it is unreasonable to make a program payment under the submitted circumstances, the repair request will be denied.

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

Name	Title	Employer

SECTION C: PRESCRIBER ATTESTATION

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 my falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature	Date