ACTION: Final

Final Ohio Department of Job and Family Selects: 12/20/2013 3:50 PM CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION REPAIR OF DURABLE MEDICAL EQUIPMENT (DME)

Contification Type		riand D 1	Dogortificatio	n .	
Certification Type					
Consumer Name		Prescriber's Name			
Consumer DOB	Consumer Sex	Consumer	HT (in.)	Consumer WT (lbs.)	
Companier 2 02	Female Male	Consumer	111 ()	Consumer vi I (1881)	
(If consumer is not residing at hom	e address)	Provider's Name			
Facility 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 Descri					
Name and description of Item being repaired (Include any make or model		Diagnosis Codes (ICD-9) of		(ICD-9) Descriptions of	
numbers)		Consumer		Consumer (Optional)	
Last Consumer Medical Examinati	on (MM/DD/YR)	<u>'</u>	1		
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)					
	The state of the s		 /		
	the age of the equipment, which should not back the equipment serviceable. The repair				
	e purchase price of the piece of equipment b	_			
Renair cases suggesting malicious	s damage, culpable neglect or wrongful disp	osition of equipment will t	equire addition	al information to be submitted	
2 00 0	nere ODJFS determines that it is unreasona		•		
repair request will be denied.					
NAME OF PERSON ANSWERIN	JG SECTION B OUESTIONS IF OTHER TH	AN PRESCRIBER (Please	Print)		
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print) Name Title Employer					
SECTION C. DDESCRIPE					
SECTION C: PRESCRIBE					
	identified above. I certify that the informat				
attached documents signed and d material fact may subject me to o	lated by me, is true to the best of my knowle	uge. 1 understand that my	, iaisiiication, oi	mssion, or conceaiment of	
Prescriber's Signature			T	Date	
					