State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

Certificate of Medical Necessity for Durable Medical Equipment/Supplies

SECTION A: TO BE COMPLETED BY PROVIDER

RECIPIENTS NAME: ______________________ Date: ______________

Medicaid ID Number: ______________________ Ht: __________ Wt: __________

DME Provider's Name: ______________________

Street Address: ______________________ City: __________ State ______

DME Provider Contact Name: ______________________ Phone: ______________

DX: ______________________ Description: ______________

Print ordering Prescriber's name: ______________________ NPI: ______________

Procedure Code(s) ______________________

SECTION B: TO BE COMPLETED OR REVIEWED AND SIGNED BY PRESCRIBER

Face-to-Face Visit Date (if applicable) ______________

Prognosis: ______________________ **DX:** ______________

How long is this problem expected to last? __________ months
Please enter number of months, 1-99 (99=Lifetime)

Functional Level Indicate recipient's ambulatory status while performing Activities of Daily Living:

☐ Non-ambulatory
☐ Ambulatory with the aid of a walker or cane
☐ Ambulatory, without assistance
☐ Ambulatory, other assistance as described ______________________

Equipment being prescribed:

____

Medical justification for request:

____

____

____

For dressing supplies, please indicate the dressing change required per day, week, month, etc. ______________

____

Duration of need: ______________ Months ______________ Lifetime
Please indicate duration by months, not to exceed 12. If lifetime please indicate above.

Please indicate the date that the recipient was last seen**:** ______________________

Prescriber Certification (must be signed and dated by prescriber)

I certify that the ordered DME and Supplies are part of my treatment plan, documented in medical record, and, in my opinion, are medically necessary.

______________________	______________________	______________
Print Ordering Prescriber's Name	**Prescriber Signature**	**Date**