

Name of provider: \_\_\_\_\_

Provider NPI # \_\_\_\_\_

Medicaid Legacy # \_\_\_\_\_

## Ohio Department of Job and Family Services Certificate of Medical Necessity/Prescription Apnea Monitor

**Instructions: The Certificate of Medical Necessity (CMN) must be used for apnea monitor under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.**

Name of recipient:		Billing Number:	
<input type="checkbox"/> Rental	Were rental dates previously approved? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", list Prior Authorization #'s: _____/_____/_____	Date of Birth
<input type="checkbox"/> Purchase			
Diagnosis(es) Include ICD-9 codes and description:		Other technology equipment is still in use. <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Other _____	

### Initial Rental (Complete section A)

#### Section A—Must be completed by physician

**Check the appropriate clinical indication(s) listed below (check all that apply to the initial rental period):**

<input type="checkbox"/> One or more apparent life-threatening events requiring mouth-to-mouth resuscitation or vigorous stimulation <input type="checkbox"/> Symptomatic preterm infant (active medical management of apnea of prematurity) <input type="checkbox"/> Sibling of one or more sudden infant death syndrome (SIDS) victims <input type="checkbox"/> Infant required home oxygen therapy or invasive/non-invasive ventilatory support (technology dependent) <input type="checkbox"/> Tracheotomized infant (technology dependent)	<input type="checkbox"/> Infant with abnormal pneumogram at discharge <input type="checkbox"/> Infants with severe upper airway abnormalities (e.g., achondroplasia, Pierre-robin syndrome, etc.) <input type="checkbox"/> Multiple birth SIDS survivor <input type="checkbox"/> Severe gastroesophageal reflux associated with apnea <input type="checkbox"/> Infants with other disorders that demonstrate a need for close cardiorespiratory monitoring to facilitate discharge. Specify: _____
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SIDS sibling: \_\_\_\_\_ Date of birth: \_\_\_/\_\_\_/\_\_\_ Sibling date of death: \_\_\_/\_\_\_/\_\_\_

#### Physician Attestation and Signature/Date

Physician's name (PRINTED) \_\_\_\_\_

**I certify that I am the physician identified above. I certify that the information I have completed in this certificate is 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.**

Physician signature: _____	Date: ___/___/___	Ohio Medicaid Provider #: _____
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### Recertification Rental (Complete section B)

#### Section B—Must be completed by physician (Complete the following or submit download summary)

**Continued monitoring** (check all that apply)

Apnea episode:      Date: \_\_\_/\_\_\_/\_\_\_      Length of episode: \_\_\_\_\_

Multiple apnea episodes:      Number: \_\_\_\_\_      Average length of episodes: \_\_\_\_\_

Bradycardia episode:      Date: \_\_\_/\_\_\_/\_\_\_      Heart rate: \_\_\_\_\_      Length of episode: \_\_\_\_\_

Multiple bradycardia episodes:      Average heart rate: \_\_\_\_\_      Average length of episode: \_\_\_\_\_

Recent emergency room visit or       Hospital admission, for ALTE      Date of visit/admission: \_\_\_/\_\_\_/\_\_\_

Infant is still in need of monitoring; Apnea monitor is effective and being used in compliance with physician's prescription

#### Physician Attestation and Signature/Date

Physician's name (PRINTED) \_\_\_\_\_

**I certify that I am the physician identified above. I certify that the information I have completed in this certificate is 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.**

Physician signature: (No stamps) _____	Date: ___/___/___	Ohio Medicaid Provider #: _____
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