

Ohio Department of Job and Family Services
Certificate of Medical Necessity/Prescription
Repair of Durable Medical Equipment (DME)

SECTION A: Consumer/Provider Information

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

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 and Descriptions:
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: <input type="checkbox"/> YES <input type="checkbox"/> 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: