

ENACTED
Appendix
5101:3-10-17

Ohio Department of Job and Family Services Certificate of Medical Necessity/Prescription Blood Glucose Monitor (Glucometer) and Supplies		
<i>Instructions: This certificate of medical necessity (CMN) must be used for a blood glucose monitor (Glucometer) 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.</i>		
Consumer Name:	Prescriber's NPI Number:	
Consumer date of birth: <input type="checkbox"/> Female <input type="checkbox"/> Male	Prescriber's Medicaid Legacy Number:	
Consumer Ht (in.) and WT (lbs.):	Prescriber's Telephone Number:	
Consumer street address:	City/State/Zip:	Consumer's Date of Birth:
Section A—Must be completed by Prescriber and/or provider of the Items/Supplies		
The consumer has the following diagnoses:		
<input type="checkbox"/> Type I Diabetes <input type="checkbox"/> Type II Diabetes <input type="checkbox"/> Gestational Diabetes Mellitus <input type="checkbox"/> Other:		
Diagnosis Codes (ICD-9):		ICD-9 Definitions:
Est. Length of Need (# of Months) 1-99 (99=LIFETIME):		
Last consumer medical examination (MM/DD/YR):		
The consumer has the following complicating conditions:		<input type="checkbox"/> Recent hospitalization as a result of uncontrolled diabetes
<input type="checkbox"/> Frequent checks of blood glucose required		<input type="checkbox"/> Current intensive insulin therapy, e.g., insulin pump, multiple daily injections
<input type="checkbox"/> Widely fluctuating blood sugars before mealtime		<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Frequent episodes of insulin reactions		
<input type="checkbox"/> Evidence of frequent significant ketosis		
<input type="checkbox"/> Yes <input type="checkbox"/> No	The consumer or caregiver is capable of being trained to use the monitor properly.	<input type="checkbox"/> Yes <input type="checkbox"/> No The device is designed for home use (rather than clinical use)
<input type="checkbox"/> Yes <input type="checkbox"/> No	The consumer requires a blood glucose monitor with special features and supplies to enable the visually impaired to use the equipment without assistance.	
<input type="checkbox"/> Yes <input type="checkbox"/> No	The consumer has a visual impairment severe enough to require use of this specialized monitor.	
(1) Narrative description of all items, accessories and options ordered; (2) Provider charge; and (3) Medicaid Fee Schedule Allowance for <u>each</u> item, accessory, and option.		
NAME OF PERSON ANSWERING SECTION A QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):		
NAME:	TITLE:	EMPLOYER:
Section B—Prescriber Attestation and Signature/Date		
Prescriber's name (PRINTED):		
<i>I certify that I am the prescriber 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.</i>		
Prescriber's signature:		Date: