

Name of provider: _____

Provider NPI # _____

Medicaid Legacy # _____

Ohio Department of Job and Family Services
**Certificate of Medical Necessity/Prescription
 Hospital Beds**

Instructions: The Certificate of Medical Necessity (CMN) must be used for all eligible hospital beds 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:
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<input type="checkbox"/> Rental	Were rental dates previously approved?	If "yes", list Prior Authorization #'s: _____, _____,	Date of Birth
<input type="checkbox"/> Purchase	<input type="checkbox"/> Yes <input type="checkbox"/> No	Authorized dates: _____, _____	

Section A—Must be completed by Physician

Pertinent Diagnoses (ICD-9 Code and Description):	Weight

Circle/Complete all that apply:

Y N Does the patient's diagnosis/physical condition require positioning of the body in ways not feasible in an ordinary bed due to a medical condition which is expected to last at least one month? (Include severity and frequency of symptoms) Explain:

Y N Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?

Y N Does the patient require traction equipment which can only be attached to a hospital bed?

Y N Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or a standing position?

Y N Is the bed required to facilitate frequent interventions by a care giver (e.g., turning the patient every two hours)?

Length of time needed:	<input type="checkbox"/> Long-term (10 months or more)
<input type="checkbox"/> Short-term (less than 10 months) Specify # of months: _____	

Y N Can the specific medical needs of the consumer be met in any other way?

Section B—Physician Attestation and Signature/Date

Physician's name (PRINTED)	Date of last face to face
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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 facts may subject me to civil or criminal liability.

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