

Ohio Department of Job and Family Services  
**Certificate of Medical Necessity/Prescription**  
**General Medical Supplies: Overage**

**Instructions: This Certificate of Medical Necessity / Prescription (CMN/Rx) must be used for Medical Supplies requiring Prior Authorization or for quantities in excess of an established allowable under the Ohio Medicaid Program. This form must be completed and carry the proper signature(s), where indicated. For requests to be considered for prior authorization, this form must be used in conjunction with Form JFS 03142.**

Consumer Name:	Billing number:
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Date of birth ____/____/____	Height / Weight ____ / ____	Attachments: <input type="checkbox"/> Price List / Invoice <input type="checkbox"/> Other:	<input type="checkbox"/> Initial Certification <input type="checkbox"/> Recertification (Prev PA# _____) <input type="checkbox"/> Change (PA # _____)
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**Section A— Medical Necessity Information**

Diagnosis(es)—include ICD-9 codes and description:	<input type="checkbox"/> Testing Supplies- Type & # Tests per day  <input type="checkbox"/> Surgical Supplies- Type & # Procedures per day  <input type="checkbox"/> Ostomy/Urological Supplies- Type & # Procedures:
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Item code	Name of Item	Total Units Required Per Day / Week / Month (indicate frequency)	Item Provided as (e.g.; ea, roll, pkg, yd, etc.) & # Units in each	Item Supplied as (e.g.; bx, ctn, cs, etc.) & # Items in each	Total Units / Other Codes <u>Billed Direct</u>	Total <u>Overage</u> Units Requested

Description of Tests / Procedures, Special Considerations, and Rationale for Overage/Quantities Requested:
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<b>Start Date:</b>	<b>End Date:</b>
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**Section B—Completion Attestation and Signature/Date**

Name of person completing form, if not prescriber ( <i>with credentials if applicable</i> ) (PRINTED):
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***I certify that I am the individual identified above. I certify that the information I have completed in 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 any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.***

Signature(No Stamps):	Date: ____/____/____	Employer:
		License #:

**Section C—Prescriber Attestation and Signature/Date**

Prescriber name (PRINTED):
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***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.***

Prescriber signature(No Stamps):	Date:	Ohio Medicaid Provider #:
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