

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

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

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

Ohio Department of Job and Family Services  
**Certificate of Medical Necessity/Prescription**  
**Bi-Level Pressure/Respiratory Assist Devices**  
 (IPPV or APAP in lieu of a Volume Ventilator - E0470, E0471, E0472)

 **Initial Certification** **Recertification**

**Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators 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:  | Date of Birth<br>____/____/____ |
| List other respiratory equipment in use: | <b>For Recertification Only -</b><br>Previous dates of service: ____/____/____<br><br>Previous approved prior authorization #: _____ |                                 |

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

Pertinent Diagnosis(es) Include ICD-9 code and description:

|  |   |
|--|---|
| Date of last examination by physician:<br>____/____/____ (must be within 30 days prior to first date of service) | <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have permanent tracheostomy |
|--|---|

Medical history (For initial certification attach hospital discharge summary, if applicable)

|   |  |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bi-Level device is required for ventilatory support, as effective alternative to a volume ventilator | <input type="checkbox"/> Yes <input type="checkbox"/> No Is a back-up mandatory breathing rate medically necessary?  |
| Ventilatory support requirements:<br><input type="checkbox"/> Continuous <input type="checkbox"/> Nocturnal only<br><input type="checkbox"/> Other, explain:  | Length of need: <input type="checkbox"/> Short term, # of months: ____<br><input type="checkbox"/> Chronic/permanent |

**Section B— Prescription, Physician Attestation and Signature/Date**

Ventilator settings/parameters prescribed:

O2 setting:

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 #: |
|----------------------------------|----------------------|---------------------------|

**Section C—Must be completed by Licensed Respiratory Care Professional (LRCP)****For Initial Certification:**

Date originally placed on ventilator: \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes  No Home evaluation prior to hospital discharge?

Yes  No Home set up?

Yes  No In-home training provided to care givers?

If "yes", check all that apply:  Ventilator operation

Tracheostomy care  Cleaning/sterilizing technique

**For Recertification:**

Yes  No Is the patient being weaned?

Yes  No Are ventilator settings/parameters in compliance with physician ordered parameters? If No, Explain:

Yes  No Is the patient using the device as prescribed?

Home visits during requested dates of service:

|                          |                   |
|--------------------------|-------------------|
| Dates: 1) ____/____/____ | 4) ____/____/____ |
| 2) ____/____/____        | 5) ____/____/____ |
| 3) ____/____/____        | 6) ____/____/____ |

LRCP name (PRINTED)

**I certify that I am the respiratory therapist 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.**

|                 |                      |            |
|-----------------|----------------------|------------|
| LRCP signature: | Date: ____/____/____ | License #: |
|-----------------|----------------------|------------|