State of Rhode Island
Executive Office of Health and Human Services
Medicaid Program

CERTIFICATE OF MEDICAL NECESSITY

SUPPORT SURFACES

SECTION A **Certificate Type/Date:** **INITIAL** _____ **REVISED** _____ **RECERTIFICATION** _____

PATIENT NAME:		SUPPLIER NAME:	
ADDRESS:		ADDRESS:	
PHONE NUMBER:		PHONE NUMBER:	
PT DOB _____ SEX _____ (M/F)		PRESCRIBER NAME:	
HEIGHT _____ (inches) WEIGHT _____ (lbs.)		ADDRESS:	
HCPCS Code: _____		PHONE NUMBER:	
		NPI # _____	

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ (Not to exceed 12) | DIAGNOSIS CODES: _____ _____

ANSWERS	ANSWER QUESTIONS 1, 7 & 8 for Alternating Pressure Pad or Mattresses; 1-9 for Air Fluidized Beds. (Circle Y for Yes, N for No)
_____	1. Enter the date of initial face-to-face evaluation.
Y N	2. Are you supervising the use of the device?
Y N	3. Does the patient have coexisting pulmonary disease?
Y N	4. Has a conservative treatment program been tried without success?
Y N	5. Was a comprehensive assessment performed after failure of conservative treatment?
Y N	6. Are open, moist dressings used for the treatment of the patient?
	7. Is there a trained full-time caregiver to assist the patient and manage all aspect involved with the use of the bed?
	8. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.
	Pressure Ulcer / Ulcer #1 / Ulcer #2 / Ulcer #3 Stage: _____ _____ _____ Max.Length (cm): _____ _____ _____ Max Width (cm): _____ _____ _____
1 2 3	9. Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please print):

NAME: _____ | TITLE: _____ | EMPLOYER: _____

SECTION C **Narrative Description of Equipment**

(1) Narrative description of all items, accessories and options ordered:

SECTION D **Prescriber Attestation and Signature/Date**

I certify that I am the physician 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 any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER SIGNATURE: _____ DATE: _____
(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE.)

Proof of medical necessity is valid for 12 months from the date of issue. 07/19