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

Certificate of Medical Necessity for Durable Medical Equipment/Supplies

SECTION A: TO BE COMPLETED BY PROVIDER

RECIPIENT NAME _____ Date _____

Recipient DOB _____

Medicaid ID number _____ Ht _____ Wt _____

DME Provider name _____

Street Address _____ City _____ State _____

DME Provider contact name _____ Phone _____

Print ordering Prescriber's name _____

Street Address _____ City _____ State _____

Procedure Code(s) _____ NPI _____

SECTION B: TO BE COMPLETED OR REVIEWED AND SIGNED BY PRESCRIBER

Face-to-Face Visit Date (if applicable) _____

Diagnosis (DX) Code _____

Functional Level- Indicate recipient's ambulatory status while performing Activities of Daily Living:

- ☐ Non-ambulatory
- ☐ Ambulatory with the aid of a walker or cane
- ☐ Ambulatory, without assistance
- ☐ Ambulatory, other assistance as described

Equipment being prescribed, including an explanation of purpose and use of item: _____

For dressing supplies, please indicate the dressing change required per day, week, month, etc. _____

Duration of need _____ Months
Please indicate duration by months, not to exceed 12. A certificate of Medical Necessity (CMN) is valid for 12 months from the date of issue. After 12 months from the date of issue, a new CMN is required.

Prescriber Certification (must be signed and dated by prescriber)

I certify that the ordered DME and Supplies are part of my treatment plan, documented in medical record, and, in my opinion, are medically necessary.

Print Ordering Prescriber's Name **Prescriber Signature** **Date**