02/23

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

Certificate of Medical Necessity for Biomarker Testing

Name: _____ DOB: _____

MID: _____

Please answer the following:

A. **I have had a face-to-face visit with the member within the last 30 days. Y___ N___. If no, has a Tumor Board or consulting specialist recommended this test? Y___ N___**
B. **Will this test confirm or rule out a diagnosis? Y __ N___**
C. **Will the results of this test be necessary to determine the correct treatment plan for this member? Y___ N ___**
D. **Is the biomarker required to prevent, diagnose, monitor, or treat complications resulting from participation in a clinical trial? Y___ N___**
E. **Is the biomarker the subject of a clinical trial or experimental protocol? Y___ N___**

Prescriber Signature: _____

Date Signed: _____ NPI: _____

Prescriber name (printed):

_____

Prescriber address: _____

Prescriber telephone #: _____

Proof of medical necessity is valid for 12 months from the date of issue