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

Certificate of Medical Necessity for Prenatal Genetic Screening

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___

B. The member has been educated on the purpose of the screening, the possible results, and the availability of additional clinical counseling based on those results. Y __ N___

C. The results of this test are necessary to determine the correct treatment plan for this member. Y___ N ___

D. Is this test related to 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