HEALTHSYSTEMS OF MISSISSIPPI
CERTIFICATE OF MEDICAL NECESSITY – CANE OR CRUTCHES AND RELATED SUPPLIES

SECTION A **BENEFICIARY AND PROVIDER INFORMATION**

Patient/Baby Name: _____
Medicaid #: _____
Date of Birth: ___/___/___ Age:_____Sex: ____ (M or F)
HT: _____ (inches) WT: _____ (lbs)
Date of last visit: _____

Ordering MD/NP/PA Name (First and Last):
_____
Medicaid ID# or MS License #: _____
Telephone #: (____) _____-_____ Ext. _____

SECTION B **CLINICAL INFORMATION**
(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-9-CM

Est. Length of Need (# of Months): ___1 – 99 *(99 = Lifetime)*

ANSWERS	CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY
	Cane:
Y N D	Does the beneficiary have an injury or condition causing impaired ambulation? If yes, specify:_____
Y N D	Is there a potential for the beneficiary to ambulate?
Y N D	Is the cane required to relieve stress on a joint postoperatively?
Y N D	Will the cane be used to aid the beneficiary with decreased balance due to vestibular, neurological, or orthopedic conditions?
Y N D	Does the beneficiary require an added base of support provided by the three prong or quad cane?
Y N D	Has the beneficiary achieved increased ambulation skills and no longer require a walker but still need an assistive device with a wider base of support than a straight cane will offer?
ANSWERS	**Crutches:**
Y N D	Are the crutches required to reduce or alleviate weight bearing of the lower extremities due to an injury or surgery?
Y N D	Does the beneficiary need assistance provided by the crutches to progress to ambulation without an assistive device?
ANSWERS	**Forearm Crutches:**
Y N D	Will the beneficiary require long-term crutch use?
Y N D	Does the beneficiary's balance require a base of support as provided by a walker?
Y N D	Does the beneficiary need assistance to increase his/her independence in the community?
Y N D	If attachments are requested, is one or both of the beneficiary's upper extremities compromised?

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

_____

_____

The Physician/Nurse Practitioner/Physician Assistant order should list each item specifically needed for the treatment of the beneficiary. Additional information may be attached to this form. Refer to the Division of Medicaid Policy for specific criteria.

SECTION C PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE AND DATE

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in Section A of this form. I certify that the medical necessity information in Section B is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the items requested in Section B of this form and that I deem them medically necessary for the patient listed in Section A. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____
Signature of Physician / Nurse Practitioner / Physician Assistant Date