HEALTHSYSTEMS OF MISSISSIPPI
CERTIFICATE OF MEDICAL NECESSITY – COMMODE CHAIRS, OTHER TOILETING AIDS 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)***

CIRCLE Y FOR YES N FOR NO or D FOR DOES NOT APPLY

ANSWERS	Commode Chair:
Y N D	Based on the beneficiary's physical condition, is he/she able to use regular toilet facilities?
Y N D	Does the beneficiary require a chair with detachable arms to facilitate transferring?
Y N D	Is the beneficiary's body configuration such that a chair with detachable arms is required to provide extra commode width?
ANSWERS	**Heavy Duty/Extra Wide Commode Chair:**
WT:_____	What is the beneficiary's current weight?
ANSWERS	**Raised Toilet Seat:**
Y N D	Does the beneficiary have a medical condition which prevents him/her from using a regular commode without a raised seat?
Y N D	Does the beneficiary have a bedside commode which can fit over the toilet?

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