HEALTHSYSTEMS OF MISSISSIPPI
CERTIFICATE OF MEDICAL NECESSITY - DIAPERS AND UNDERPADS

SECTION A BENEFICIARY AND PROVIDER INFORMATION

Beneficiary 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. _____

Fax #:

SECTION B CLINICAL INFORMATION

(THIS SECTION MUST BE COMPLETED BY THE PHYSICIAN/NP/PA.)

DIAGNOSES	ICD-9-CM
INCONTINENCE	N39.498

Est. Length of Need (# of Months): 99 1 – 99 *(99 = Lifetime)*

ANSWERS	Complete the following questions: Circle Y (Yes) - N (No) – or D (Does Not Apply)
(Y) N D	Does the beneficiary have an underlying medical condition that prevents control of bowels or bladder?
Y (N) D	Are there extenuating circumstances, in which the beneficiary requires more than six (6) diapers or underpads per day? If so, provide full documentation that justifies the medical necessity.
(Y) N D	Is certification being requested for a twelve (12) month time span? If so, provide full documentation justifying the need for the diapers or underpads for the beneficiary whose medical condition is not expected to improve.

PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT ORDER:

Please circle item(s) and size needed and answer questions below. Condition not expected to improve.

Item: diapers underpads gloves (2 boxes) wipes barrier cream

Size: S M L XL 2XL

Q1: (Y) N Is the beneficiary unable to utilize regular toilet facilities due to documented medical condition?

Q2: (Y) N Is the beneficiary unable to to physically turn or reposition self?

Q3: (Y) N Is the beneficiary unable to transfer self from bed, chair or wheelchair without assistance?

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