INCO-MED LLC RETURN FAX TO: 601-675-4168

Certificate of Medical Necessity (CMN) – Incontinence Supplies - Fee for Service

Mississippi Division of Medicaid

Beneficiary Medicaid ID #:_____**DOB:**_____

Beneficiary Full Name:_____ **Height**_____ **Weight**_____**(lbs)**

Ordering Prescriber Medicaid ID # _____**Phone:**_____

Prescriber Full Name:_____**FAX:**_____

DME Provider Medicaid ID #: 05236002 **Phone:** 601-847-5157

DME Provider Name: INCO-MED LLC **FAX:** 601-675-4168

Nurse Practitioners(NP)/Physician Assistants (PA) Only –*must complete*

Collaborating Physician's NPI #:_____**Collaborating Physician's MS Medicaid #:**_____

SUPPLIES INFORMATION

Medical Diagnosis causing the urine and/or fecal Incontinence(specific ICD-10 CM code):			
Primary:		Secondary:	

Patient Mobility(check All that apply)

Is beneficiary able to control bowel or bladder function	Yes		No	
Is beneficiary able to use regular toilet facilities	Yes		No	
Is beneficiary able to transfer from bed to chair/wheelchair without assistance	Yes		No	
Is beneficiary able to physically turn or reposition themselves	Yes		No	

Description of Items requested Can have any combination of underpad, diaper, and or pull-ons not to exceed 186 units total a month (6 units per day)	**HCPCS Code**	**Initial Order Date**	**Expected Length of Need** (# of Months) 1-999 (999=Lifetime)	**Quantity Per Month**
UNDERPADS	A4554		999	UP TO 186 UNITS
DIAPERS			999	UP TO 186 UNITS
PULL-ONS			999	UP TO 186 UNITS
SKIN PROTECTANT CREAM	A6250		999	2 4OZ TUBE
WIPES	A9999		999	96 EA
GLOVES	A4927		999	

Medical Justification:
PATIENT NEEDS SUPPLIES DUE TO DIAGNOSIS

DME Provider Attestation, Signature and Date

I certify that the items listed on this form are the exact items offered and certified as medically necessary by the ordering, prescribing provider whose signature appears on this form, and these exact items will be delivered to the beneficiary listed on this form. I will not knowingly present or cause to be presented false or fraudulent information, including presenting information with deliberate ignorance or reckless disregard for its truth or falsity. Further, I certify that the information contained herein is true, correct, and complete to the best of my knowledge, and authorize DOM to verify this information. I understand that any omission, misrepresentation, or falsification of any information presented in any application for Medicaid benefits or Medicaid payments may be punishable by criminal, civil, or other administrative actions. A false attestation may result in civil monetary penalties, as well as fines, and may disqualify the provider from participation in the Medicaid program.

DME Provider Representative(print full name)_____

DME Provider Representative Signature:_____ **Date:**_____

Prescriber Attestation, Signature and Date

I, a physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed durable medical equipment, orthotics, prosthetics, or medical supplies, will not knowingly present or cause to be presented false or fraudulent information, including presenting information with deliberate ignorance or reckless disregard for its truth or falsity. 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, correct, and complete to the best of my knowledge, and authorize DOM to verify this information. 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, misrepresentation, or concealment of any information presented in any application for Medicaid benefits or Medicaid payments may be punishable by criminal, civil, or other administrative actions. A false attestation may result in civil monetary penalties, as well as fines, and may disqualify me from participation in the Medicaid program.

Prescribing Provider Name (please print full name) _____

Prescribing Provider Signature:* _____**Date:*** _____

Prescribing provider's signature (stamped signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

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Instructions:

CMN for Incontinence Supplies must contain

1.) Beneficiary's Mississippi Medicaid Identification number, Date of Birth (DOB) and Beneficiary full name.
2.) Prescribing Providers Mississippi Medicaid Identification number, full name, FAX and current telephone number.
3.) DME providers Mississippi Medicaid Identification number, DME Providers name (business name) current FAX number and telephone number.
4.) The beneficiaries specific diagnoses along with associated ICD-10 code(s)
5.) Item(s) description, associated HCPCS code(s), initial order date, expected length of use in months (999=lifetime) and requested quantity needed per month.
6.) Physician/Nurse Practitioner/Physician Assistant Order if needed or required. The CMN can serve as the physician's detailed written order if the narrative description in the "supplies needed" section is sufficiently detailed. This would include quantities needed and frequency of replacement for accessories and supplies.
7.) DME representative responsible for the CMN name, signature and date of signature.
8.) Prescribing Providers signature and date of signature. Signature stamps, date stamps, or the signature of anyone other than the provider is not acceptable.