

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
GENERAL MEDICAL SUPPLIES: OVERAGE

Name of Provider _____
Provider NPI # _____
Medicaid Legacy # _____

Instructions: This Certificate of Medical Necessity / Prescription (CMN/Rx) must be used for Medical Supplies requiring Prior Authorization or for quantities in excess of an established allowable under the Ohio Medicaid Program. This form must be completed and carry the proper signature(s), where indicated.

Medicaid Recipient Name		Billing Number	
Date of Birth	Height / Weight	Attachments: <input type="checkbox"/> Price List / Invoice <input type="checkbox"/> Other	<input type="checkbox"/> Initial Certification <input type="checkbox"/> Recertification (Prev PA # _____) <input type="checkbox"/> Change (PA # _____)

Section A - Medical Necessity Information

Diagnosis(es) - include ICD-10 codes and description:	<input type="checkbox"/> Testing Supplies - Type & # Tests per day <input type="checkbox"/> Surgical Supplies - Type & # Procedures per day <input type="checkbox"/> Ostomy/Urological Supplies - Type & # Procedures
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Item Code	Name of Item	Total Units Required Per Day / Week / Month (indicate frequency)	Item Provided as (e.g., ea, roll, pkg, yd, etc.) & # Units in each	Item Supplied as (e.g., bx, ctn, cs, etc.) & # Items in each	Total Units / Other Codes Billed Direct	Total Overage Units Requested

Description of Tests / Procedures, Special Considerations, and Rationale for Overage/Quantities Requested:

Start Date	End Date
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Section B - Completion Attestation and Signature/Date

Name of person completing form, if not prescriber (with credentials if applicable) (PRINTED)

I certify that I am the individual identified above. I certify that the information I have completed in this certificate of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature (No Stamps)	Date	Employer	License #
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Section C - Prescriber Attestation and Signature/Date

Prescriber Name (PRINTED)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature (No Stamps)	Date	Ohio Medicaid Provider #
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