



Affiliated Computer Services, Inc.
Certificate of Medical Necessity, Page 1 of 2

ACS is now a Xerox company

Submitted by: _____

Date: _____

Recipient Name: _____

Ordering Provider's Name: _____

Medicaid #: _____

Medicaid ID# or AK License #: _____

Date of Birth: ___/___/___ Age: ___ Sex: ___ (M or F)

Telephone #: (___) ___-___ Ext. ___

HT: ___ (inches) WT: ___ (pounds)

Retrospective Review? ___ (Y/N)

Date of last visit: _____

SECTION A: CLINICAL INFORMATION

(THIS SECTION **MUST** BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT OR AUDIOLOGIST.)

DIAGNOSIS

ICD-9-CM

Estimated Length of Need (# of Months): _____ 1 – 99 (99 = Lifetime)

SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN: Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. (THIS SECTION MAY BE COMPLETED BY THE ATTENDING SPECIALIST, INCLUDING THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH LANGUAGE PATHOLOGY THERAPIST, REGISTERED DIETITIAN, AUDIOLOGIST, OR OTHER ATTENDING SPECIALIST WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)

PLAN: The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.

ATTESTATION, SIGNATURE AND DATE OF AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST (Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

A physician, nurse practitioner, physician assistant, audiologist or specialist who attests to the medical necessity of the prescribed items, 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 certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

Signature of Specialist – Title

Date

This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.

Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant

Date

I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.



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Affiliated Computer Services, Inc. Certificate of Medical Necessity, Page 2 of 2

ACS is now a Xerox company

Submitted by: _____

Date: _____

Recipient Name: _____

Medicaid #: _____

Date of Birth: ___/___/___ Age: ___ Sex: ___ (M or F)

Ordering Provider's Name: _____

Medicaid ID# or AK License #: _____

Telephone #: (____) _____ - _____ Ext. _____

SECTION C: REQUESTED SERVICES OR ITEMS
(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)

Provider Name: _____

Address: _____

Provider Medicaid No.: _____

Requester Name: _____

Telephone #: (____) _____ Ext. _____

Fax #: (____) _____ Ext. _____

Dates of Need – Start Date: _____ End Date: _____

ACS Use Only

Your request is:

Approved as requested

Approved as modified
(Items marked as authorized may be claimed.)

Prior Authorization Number: _____

From Date: _____ Thru Date: _____

Denied

Authorizing Agent Signature & Date: _____

Comments: _____

| | Procedure Code | Mod. | Description | QTY (#) | Charges | Authorized | | Approved Quantity | Approved Amount |
|----|----------------|------|-------------|---------|---------|------------|----|-------------------|-----------------|
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SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Signature of Supplier

Date

Affiliated Computer Services, Inc.
Certificate of Medical Necessity for Incontinence Supplies, Page 1 of 2

| | |
|---|---|
| Recipient Name: _____ Medicaid #: _____ Date of Birth: ___/___/___ Age: ___ Sex: ___ (M or F) | Ordering Provider's Name: _____ Medicaid ID # or AK License #: _____ Telephone #: (____) _____ - _____ Ext. _____ |
| HT: _____ (inches) WT: _____ (pounds) Date of last visit: _____ | Retrospective Review? _____ (Y/N) |

SECTION A: CLINICAL INFORMATION
 (THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT.)

| DIAGNOSIS | ICD-9-CM |
|-----------|----------|
| | |

Estimated Length of Need (# of Months): _____ 1-99 (99=Lifetime)

SECTION B: CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEMS(S) AND PLAN
 Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. (THIS SECTION MAY BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN ASSISTANT WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)

Plan: The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.

| | |
|---|--|
| <p><u>Daily</u> Usage Supplies (circle appropriate quantity):</p> <p>Disposable brief/undergarment 1 2 3 4 5 6 7 8 Other qty _____*</p> <p>Insert pads (used in briefs) 1 2 3 4 5 6 7 8 Other qty _____*</p> <p>Disposable bed pads 1 2 3 4 5 Other qty _____*</p> <p>** 1 unit = one tube or bottle up to 4 oz in size Ointment & Cream normally come in grams. Note: 1 oz = 30 gm or 30 ml</p> <p>***Note to supplier: If the packaging quantity is not the same as the 100/200/300/400/500 quantity circled, you may round to the nearest size packaging to avoid breaking open a package</p> | <p><u>Monthly</u> Usage Supplies (circle appropriate quantity):</p> <p>Reusable Bed Pads w/ or w/out flaps 1 2 3 4 Other qty _____*</p> <p>Gloves (per month): 100 200 300 400 Other qty _____*</p> <p>** Moisture Barrier Ointment/Gel 1 2 3 4 Other qty _____*</p> <p>** Moisture Barrier Cream 1 2 3 4 Other qty _____*</p> <p>** Moisture Barrier Lotion 1 2 3 4 Other qty _____*</p> <p>** Protectant Powder 1 2 3 4 Other qty _____*</p> <p>** Skin Cleanser 1 2 3 4 Other qty _____*</p> <p>*** Disposable wipes (each) 100 200 300 400 500 Other qty _____*</p> <p>*** Disposable wash cloths (each) 100 200 300 400 500 Other qty _____*</p> |
|---|--|

* If "other quantity" is completed, you must provide additional medical justification for the higher quantity requested.

Please note: These supplies are for incontinence treatment only and not for treatment of other areas of the body.

A physician, nurse practitioner, or physician assistant who attests to the medical necessity and quantity of the prescribed items, 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 certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

| | |
|--|---------------|
| _____ Signature of Provider – Title | _____ Date |
|--|---------------|

I hereby certify that I am the ordering physician, nurse practitioner or physician assistant identified in this form above.

Sections A and B must be completed by the attending physician, nurse practitioner or physician assistant.

Affiliated Computer Services, Inc.
Certificate of Medical Necessity for Incontinence Supplies, Page 2 of 2

Submitted by: _____

Date: _____

Recipient Name: _____
 Medicaid #: _____
 Date of Birth: ___/___/___ Age: _____ Sex: _____ (M or F)

Ordering Provider's Name: _____
 Medicaid ID# or AK License #: _____
 Telephone #: (____) _____ - _____ Ext. _____

SECTION C: REQUESTED SERVICES OR ITEMS
(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers.)

Provider Name: _____
 Address: _____

Provider Medicaid #: _____
 Requester Name: _____
 Telephone #: (____) _____ Ext. _____
 Fax #: (____) _____ Ext. _____
Dates of Need – Start Date: _____ **End Date:** _____

ACS Use Only

Your request is:

- Approved as requested**
 Approved as modified
 (Items marked as authorized may be claimed.)

Prior authorization number: _____

From Date: _____ **Thru Date:** _____

Denied
Authorizing Agent Signature & Date: _____

Comments: _____

| | Procedure Code | Mod. | Description | QTY (#) | Charges | Authorized | | Approved Quantity | Approved Amount |
|----|----------------|------|-------------|---------|---------|------------|----|-------------------|-----------------|
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SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

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 Signature of Supplier

 Date

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Table I-1. 2010 HCPC Fee Schedule For Incontinence Supplies

| Code | Description | Fee |
|-------------|---|------------|
| A4336 * | INCONTINENCE SUPPLY, URETHRAL INSERT, ANY TYPE, EACH | By Report |
| A4927 * | GLOVES, NON-STERILE, PER 100 | \$7.86 |
| T1999 * | MISCELLANEOUS THERAPEUTIC ITEMS AND SUPPLIES, RETAIL PURCHASES, NOT OTHERWISE CLASSIFIED; IDENTIFY PRODUCT IN "REMARKS" Wipes and washcloths \$0.07 | \$0.07 |
| T4521 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL, EACH | \$0.56 |
| T4522 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, MEDIUM, EACH | \$0.76 |
| T4523 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE, EACH | \$0.91 |
| T4524 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EXTRA LARGE, EACH | \$1.06 |
| T4525 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL SIZE, EACH | \$0.90 |
| T4526 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, MEDIUM SIZE, EACH | \$0.91 |
| T4527 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH | \$1.07 |
| T4528 * | ADULT SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EXTRA LARGE SIZE, EACH | \$1.08 |
| T4529 * | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, SMALL/MEDIUM SIZE, EACH | \$0.56 |
| T4530 * | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, LARGE SIZE, EACH | \$0.59 |
| T4531 * | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, SMALL/MEDIUM SIZE, EACH | \$0.56 |
| T4532 * | PEDIATRIC SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, LARGE SIZE, EACH | \$0.71 |

* = PA Required

Incontinence Supplies

Effective for dates of service on or after 1/1/2010

Publishing date: 3/4/2010

Table I-1. 2010 HCPC Fee Schedule For Incontinence Supplies

| Code | Description | Fee |
|-------------|---|------------|
| T4533 * | YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, EACH | \$0.60 |
| T4534 * | YOUTH SIZED DISPOSABLE INCONTINENCE PRODUCT, PROTECTIVE UNDERWEAR/PULL-ON, EACH | \$0.96 |
| T4535 * | DISPOSABLE LINER/SHIELD/GUARD/PAD/UNDERGARMENT, FOR INCONTINENCE, EACH | \$0.43 |
| T4537 * | INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, BED SIZE, EACH | \$16.88 |
| T4540 * | INCONTINENCE PRODUCT, PROTECTIVE UNDERPAD, REUSABLE, CHAIR SIZE, EACH | \$16.88 |
| T4541 * | INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, LARGE, EACH | \$0.43 |
| T4542 * | INCONTINENCE PRODUCT, DISPOSABLE UNDERPAD, SMALL SIZE, EACH | \$0.35 |
| T4543 * | DISPOSABLE INCONTINENCE PRODUCT, BRIEF/DIAPER, BARIATRIC, EACH | \$4.32 |

* = PA Required

Incontinence Supplies

Effective for dates of service on or after 1/1/2010

Publishing date: 3/4/2010