

CERTIFICATE OF MEDICAL NECESSITY

Patient Name	Medicaid ID Number
Date Billed	Description of Item/Service
Procedure Code	
Reason for Item/Service/Equipment/Supplies	
Date Prescribed	Diagnosis
Prognosis	
Attending/Prescribing Physician Name/Medicaid Contract ID/NPI <div style="text-align: right; margin-right: 100px;"> _____ Signature </div>	
Provider Name, Address, Medicaid Contract ID and NPI	
Provider Signature	Title

Please attach this form to all claims requiring documentation of medical necessity.