

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO.0938-0679
DMERC 02.03BCERTIFICATE OF MEDICAL NECESSITY
MANUAL WHEELCHAIRS

SECTION A Certification Type/Date: INITIAL / / REVISED / /		
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER () - HICN		
SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER () - NSC#		
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____	
PT DOB / / SEX (M/F) HT (IN.) WT (lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER () - UPIN #		
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.		
EST. LENGTH OF NEED (# OF MONTHS) _____ 1-99 (99=LIFETIME)		
DIAGNOSIS CODES (ICD-0) _____		
ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 5 AND 8 AND 9 FOR MANUAL WHEELCHAIR BASE. 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
Manual Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Ht. Armrest; Any Tpe Ltwt. Whlchr	-----	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)
Any Type Ltwt. Whlchr	Y N D	8. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
Any Type Ltwt. Whlchr	Y N D	9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print) NAME: _____ TITLE: _____ EMPLOYER: _____		
SECTION C Narrative Description Of Equipment And Cost		
(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back). If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.		
<input type="checkbox"/> CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA Form 854		
SECTION D Physician Attestation and Signature/Date		
I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.		
PHYSICIAN'S SIGNATURE _____ DATE / / (SIGNATURE AND DATE STAMPS NOT ACCEPTABLE)		

SECTION A:	(May be completed by the supplier)
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL", <u>and also</u> indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL" <u>and also</u> indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED <u>or</u> RECERTIFICATION date.
PATIENT INFORMATION	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on this/her Medicare card on the claim form.
SUPPLIER INFORMATION:	Indicate the name of our company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME	If the place of service is a facility, indicate the name and complete address of the facility
HCPCS CODES	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B	(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)
EST. LENGTH OF NEED	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must <u>print</u> his/her name, give his/her professional title and the name of his/her employer where indicated. If the <u>physician</u> is answering the questions, this space may be left blank.
SECTION C:	(To be completed by the supplier)
NARRATIVE DESCRIPTION OF EQUIPMENT & COST	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drug; (2) the supplier's charge for each item, option, accessory, supply and drug; and (3) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D	(To be completed by the physician)
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.