Appendix B – Medicaid Certificate of Medical Necessity

Delaware Division of Social Services
MEDICAID CERTIFICATE OF MEDICAL NECESSITY
(Request for Prior Authorization for Medical Supplies and Equipment)

The following information must be provided in order for the supplier of medical supplies and equipment to receive a Prior Authorization (PA) number to bill Medicaid.

*****Please note that supplies include nutritional supplementation*****

This form must be completed by the DME provider. The bottom of the form must then be completed by the patient's/client's attending practitioner and forwarded to the Medicaid office.

DME Provider Name:_____
DME Provider Address:_____
DME Provider ID#:_____

Patient/Client Name:_____
Medicaid ID#:_____
Patient/Client Diagnosis:_____
Dates of Services (not to exceed six (6) months:_____ **Through** _____

One PA# may be used for up to five items in either category. If more than five items are needed, a second PA# will be issued.

SUPPLIES

HCPCS Code	TOS(1)	Description (2)	# of Units(3)	U & C Charge

EQUIPMENT

(1)TOS-Type of service: Use "NU" for Purchase New, "UE" for Purchase Used, or "RR" for Rental
(2) Include the Brand Name and Serial/Product Number as part of the description
(3) For Enteral Supplements, enter calories in addition to units

Important: The following section must be completed by the patient/client's attending practitioner before supplies/equipment may be considered for payment by Medicaid.

I certify that the services described above are medically necessary for the identified patient/client and that use of other, less technically complex items would be detrimental to the health and functioning of this patient.

_____ _____
(Attending Practitioner's Signature) **(Date Signed)**
PRINT or TYPE the following
Practitioner's Name:_____
Address:_____
_____ **Phone #**_____