

**CERTIFICATE OF MEDICAL NECESSITY
EXTERNAL INFUSION PUMP**

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___	
PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER (___) ___ - ___ MEMBER # _____	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER (___) ___ - ___ NSC OR NPI # _____
PLACE OF SERVICE _____	HCPCS CODE _____
NAME and ADDRESS of FACILITY <i>If applicable</i> _____ _____ _____	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___(in) Wt. ___(lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER (___) ___ - ___ NSC OR NPI # _____
SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.	
EST. LENGTH OF NEED (# OF MONTHS); _____ I-99 (99=LIFETIME)	DIAGNOSIS CODES : _____
ANSWERS	ANSWER QUESTIONS 1-7 FOR EXTERNAL INFUSION PUMP. (Circle Y for Yes, N for No or D for Does Not Apply, Unless Otherwise Noted).
I 3 4	1. Circle number of pump which has been prescribed 1---External infusion pump (non disposable) 2---Reserved for other or future use 3---Implantable infusion pump 4---Disposable infusion pump (e.g. elastometric)
HCPCS CODE _____	2. Provide the HCPCS code for the drug that requires the use of the pump. 3. If non-specific code was used to answer question print the name of the drug.
I 3 4	4. Circle number for route administration. 1---Intravenous 2---Reserved for other or future use 3---Epidural 4---Subcutaneous
I 2 3	5. Circle number for method of administration. 1---Continuous 2---Intermittent 3---Bolus
_____	6. What is the total duration of drug infusion per 24 hours? (1-24). _____
Y N D	7. Does the patient have intractable cancer pain, which has failed to respond to an adequate oral/transdermal narcotic analgesic regime, or is the patient unable to tolerate oral/transdermal narcotics?
To expedite timely review, medical records to support the above statement must be submitted at the time of request.	
NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PYSICIAN (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) Fee Schedule Allowance for each item, accessory, and option. 	
SECTION D PHYSICIAN Attestation and Signature/Date	
I certify that I am the treating 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 ___/___/___	