Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
PNEUMATIC COMPRESSION DEVICES

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	PT DOB ____ /____ /____ Sex ____ (M/F) Ht. ____ (in) Wt. _____ (lbs.)
NAME and ADDRESS of FACILITY *If applicable*		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); _____1-99 (99=LIFETIME)	DIAGNOSIS CODES : _____ _____ _____ _____

ANSWERS		ANSWER QUESTIONS 1-5 FOR PNEUMATIC COMPRESSION DEVICES (Circle Y for Yes, N for No unless otherwise noted
Y	N	1. Does the patient have chronic venous insufficiency with venous stasis ulcer?
Y	N	2. If the patient has venous stasis ulcers, have you seen the patient regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?
Y	N	3. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?
Y	N	4. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of the extremity?
Y	N	5. Has the patient had lymphedema since childhood or adolescence?

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 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.

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 _____ /_____ /_____