CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1978	**Date: November 17, 2017**
	Change Request 10367

SUBJECT: Implementation of Changes to Certificate of Medical Necessity (CMN) and CMN DME Information Form (CMN DIF) as a result of the New Medicare Card Project

I. SUMMARY OF CHANGES: Updating the Medicare systems to incorporate changes to the Certificate of Medical Necessity (CMN) and CMN Durable Medical Equipment (DME) Information Form (DIF). These changes include removal of Health Insurance Claim Number (HICN) with the new Medicare Beneficiary Identifier (MBI). We are also adding an expiration date to each form per Office of Management and Budget (OMB) guidelines.

EFFECTIVE DATE: April 1, 2018 - effective date based on process date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1978	Date: November 17, 2017	Change Request: 10367

SUBJECT: Implementation of Changes to Certificate of Medical Necessity (CMN) and CMN DME Information Form (CMN DIF) as a result of the New Medicare Card Project

EFFECTIVE DATE: April 1, 2018 - effective date based on process date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

I. GENERAL INFORMATION

A. Background: This Change Request (CR) instructs the DME Medicare systems contractors to update their systems to implement CMN changes for the new Medicare Beneficiary Identifier (MBI). The MBI must be submitted on claims, translated to the Health Insurance Claim Number (HICN) for processing, and translated back to the MBI for outgoing communications. These changes will be implemented in several phases. In addition, DME Medicare contractors must add an expiration date of February 1, 2020 to all CMNs and CMN DIFs on their websites and forms.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based HICN from Medicare cards within four (4) years of enactment. The Centers for Medicare & Medicaid Services (CMS) will be establishing a new MBI that will replace the HICN on the Medicare card.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10367.1	GDIT shall modify the VMS Certificate of Medical Necessity subsystem (VDME) to allow for the following: 1. The look-up of CMN data by the MBI, as an alternative to the HICN 2. The entry of the MBI as the beneficiary identifier on new or updated CMNs and the translation of entered MBIs to HICNs. 3. The display of the MBI on designated VDME screens.							X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10367.2	GDIT shall modify VMS to systematically reprocess CMNs submitted with an MBI against the CWF Translation Service when the HICN could not be obtained for the CMN because the CWF Translation Service was unavailable at the time the CMN entered the system.							X		
10367.3	DME MACs shall use the attached versions of the CMN and DIF forms, and the DME MACs shall load these forms to their websites.				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Paula Smith, 410-786-4709 or Paula.Smith@cms.hhs.gov , Teresa Dangerfield, 410-786-0960 or Teresa.Dangerfield1@cms.hhs.gov , Phillip Kendall, 410-786-8817 or Phillip.Kendall@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2020

DME INFORMATION FORM
CMS-10125 — EXTERNAL INFUSION PUMPS

DME 09.03

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and Medicare ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____	SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbs.)
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____
ANSWERS		ANSWER QUESTIONS 1–4 FOR EXTERNAL INFUSION PUMP.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S): a) _____ b) _____ c) _____		1. Provide the Supply Item/Service Procedure code(s) for the drug(s) that requires the use of the pump.
a) _____ b) _____ c) _____		2. If a NOC (not otherwise classified) Supply Item/Service Procedure code is listed in question 1, print name of drug.
❑ 1 ❑ 2 ❑ 3 ❑ 4		3. Check number for route of administration? 1 – Intravenous 2 – Subcutaneous 3 – Epidural 4 – Other
❑ 1 ❑ 2		4. Check number for method of administration? 1 – Continuous 2 – Intermittent

Supplier Attestation and Signature/Date

I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate, and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.

SUPPLIER SIGNATURE_____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR EXTERNAL INFUSION PUMPS (CMS-10125)

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," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODES:	List all HCPCS procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
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 required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
SUPPLIER ATTESTATION:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
SUPPLIER SIGNATURE AND DATE:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2020

DME 10.03

DME INFORMATION FORM
CMS-10126 — ENTERAL AND PARENTERAL NUTRITION

All INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
(__ __ __) __ __ __ - __ __ __ __ Medicare ID		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE_____	Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbs.)
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____
EST. LENGTH OF NEED (# OF MONTHS): _____ 1–99 *(99=LIFETIME)*		DIAGNOSIS CODES: _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–6 FOR ENTERAL NUTRITION, AND 6–9 FOR PARENTERAL NUTRITION (Check Y for Yes, N for No, Unless Otherwise Noted)
☐ Y ☐ N	1. Is there documentation in the medical record that supports the patient having a permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?
☐ Y ☐ N	2. Is the enteral nutrition being provided for administration via tube? (i.e., gastrostomy tube, jejunostomy tube, nasogastric tube)
A)_____ B)_____	3. Print Supply Item/Service Procedure Code(s) of product.
A)_____ B)_____	4. Calories per day for each corresponding Supply Item/Service Procedure Code(s).
☐ 1 ☐ 2 ☐ 3 ☐ 4	5. Check the number for method of administration? 1 – Syringe 2 – Gravity 3 – Pump 4 – Oral (i.e. drinking)
_____	6. Days per week administered or infused (Enter 1–7)
☐ Y ☐ N	7. Is there documentation in the medical record that supports the patient having permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?
	8. Formula components: Amino Acid _____(ml/day)_____concentration % _____ gms protein/day Dextrose_____(ml/day)_____concentration % Lipids_____(ml/day)_____days/week _____ concentration %
☐ 1 ☐ 2 ☐ 3	9. Check the number for the route of administration. 1 – Central Line (Including PICC) 2 – Hemodialysis Access Line 3 – Peritoneal Catheter

Supplier Attestation and Signature/Date

I certify that I am the supplier identified on this DME Information Form and that the information provided is true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact associated with billing this service may subject me to civil or criminal liability.

SUPPLIER SIGNATURE_____ DATE _____/_____/_____

INSTRUCTIONS FOR COMPLETING DME INFORMATION FORM FOR ENTERAL AND PARENTERAL NUTRITION (CMS-10126)

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," and also indicate the revision date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFICATION DIF, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered that require a DIF. Procedure codes that do not require certification should not be listed in this section of the DIF.
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 required.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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.
QUESTION SECTION:	This section is used to gather clinical information about the item or service billed. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, a number if this is offered as an answer option, or fill in the blank if other information is requested.
SUPPLIER ATTESTATION:	The supplier's signature certifies that the information on the form is an accurate representation of the situation(s) under which the item or service is billed.
SUPPLIER SIGNATURE AND DATE:	After completion, supplier must sign and date the DME Information Form, verifying the Attestation.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires **02**/2020

CERTIFICATE OF MEDICAL NECESSITY
CMS-854 — CONTINUATION FORM

DME 11.02

PATIENT NAME	**MEDICARE ID**

SECTION C Narrative Description of Equipment and Cost *(continued)*

(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.)

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 _____/_____/_____

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY SECTION C CONTINUATION FORM (CMS-854)

SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Provide (1) a narrative description of the item(s) ordered, as well as all options, accessories; (2) the product, model and serial number of the product being delivered (if applicable); (3) the supplier's charge for each item, option, accessory; and (4) 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

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see *http://www.medicare.gov/* for information on claim filing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2020

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

DME 07.03A

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____		(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____	Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN 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 SEAT LIFT MECHANISM (Check Y for Yes, N for No, or D for Does Not Apply)
❑ Y ❑ N ❑ D	1. Does the patient have severe arthritis of the hip or knee?
❑ Y ❑ N ❑ D	2. Does the patient have a severe neuromuscular disease?
❑ Y ❑ N ❑ D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
❑ Y ❑ N ❑ D	4. Once standing, does the patient have the ability to ambulate?
❑ Y ❑ N ❑ D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

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)

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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR SEAT LIFT MECHANISMS (CMS-849)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space TYPE/ 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," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and 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 or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. 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.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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 treating practitioner.)**
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 patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician 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 drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, 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's 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.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.

Form Approved OMB
No. 0938-0679
Expires 02/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

CERTIFICATE OF MEDICAL NECESSITY

DME 06.03B

CMS-848 — TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____	(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____ Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbs
NAME and ADDRESS of FACILITY *if applicable (see reverse)* _____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN 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 1–6 for purchase of TENS (Check Y for Yes, N for No,)
❑ Y ❑ N	1. Does the patient have chronic, intractable pain?
_____ Months	2. How long has the patient had intractable pain? (Enter number of months, 1–99.)
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5	3. Is the TENS unit being prescribed for any of the following conditions? (Check appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above
❑ Y ❑ N	4. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
❑ Y ❑ N	5. Has the patient received a TENS trial of at least 30 days?
_____/_____/_____	6. What is the date that you reevaluated the patient at the end of the trial period?

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)

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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) (CMS-848)

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," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and 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 or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. 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.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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 treating practitioner.)**
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 patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician 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 drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, 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's 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.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2020

DME 04.04C

CERTIFICATE OF MEDICAL NECESSITY
CMS-847 — OSTEOGENESIS STIMULATORS

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ – __ __ __ __ Medicare ID		(__ __ __) __ __ __ –__ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____	Supply Item/Service/Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____
NAME and ADDRESS of FACILITY if applicable (see reverse)		PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI #
		(__ __ __) __ __ __ – __ __ __ __ UPIN 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	QUESTIONS 1–5 ARE BLANK. ANSWER QUESTIONS 6–8 FOR NONSPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 9–11 FOR SPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 6 AND 12 FOR ULTRASONIC OSTEOGENSIS STIMULATOR. (Check Y for Yes, N for No, or D for Does Not Apply. For questions about months, enter 1–99 or D. If less than one month, enter 1.)
a) Y N D	6. In a fracture, has there been no clinically significant radiographic evidence of healing for a minimum of 90 days?
a) Y N D b)_____	7. (a) Does the patient have a failed fusion of a joint other than the spine? (b) How many months prior to ordering the device did the patient have the fusion?
Y N D	8. Does the patient have a congenital pseudoarthrosis?
a) Y N D b)	9. (a) Is the device being ordered as a treatment of a failed single level spinal fusion surgery in a patient who has not had a recent repeat fusion? (b) How many months prior to ordering the device did the patient have the fusion?
a) Y N D b)_____ c)_____	10. (a) Is the device being ordered as an adjunct to repeat single level spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s)? (b) How many months prior to ordering the device did the patient have the repeat fusion? (c) How many months prior to ordering the device did the patient have the previously failed fusion?
Y N D	11. Is the device being ordered following multi¬level spinal fusion surgery?
Y N D	12. Has there been at least one open surgical intervention for treatment of the fracture?

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 lall items, accessories and option ordered; (2) Suppliers charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option (see instructions on back)

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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OSTEOGENESIS STIMULATORS

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space TYPE/ 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," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and 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 or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. 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.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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 treating practitioner.)**
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 patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician 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 drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, 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's 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.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.

Form Approved OMB
No. 0938-0679
Expires 02/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

DME 04.04B

CERTIFICATE OF MEDICAL NECESSITY
CMS-846 — PNEUMATIC COMPRESSION DEVICES

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____	(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____ Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbss
NAME and ADDRESS of FACILITY *if applicable (see reverse)* _____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN 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 CODE(S): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–5 FOR PNEUMATIC COMPRESSION DEVICES (Check Y for Yes, N for No, Unless Otherwise Noted)
❑ Y ❑ N	1. Does the patient have chronic venous insufficiency with venous stasis ulcers?
❑ 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 an extremity?
❑ Y ❑ N	5. Has the patient had lymphedema since childhood or adolescence?

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)

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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR PNEUMATIC COMPRESSION DEVICES (CMS-846)

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," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and 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 or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. 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.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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 treating practitioner.)**
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 patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician 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 drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, 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's 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.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved OMB
No. 0938-0679
Expires 02/2020

CERTIFICATE OF MEDICAL NECESSITY CMS-484 OXYGEN

DME 484.03

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ – __ __ __ __ Medicare ID	(__ __ __) __ __ __ – __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____ Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____
NAME and ADDRESS of FACILITY if applicable (see reverse)	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI #
	(__ __ __) __ __ __ – __ __ __ __ UPIN 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 1–9. (Check Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
a)_____mm Hg b)_____% c)____/____/____	1. Enter the result of recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test; (c) date of test.
❑ 1 ❑ 2 ❑ 3	2. Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?
❑ 1 ❑ 2 ❑ 3	3. Check the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
❑ Y ❑ N ❑ D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, check D.
_____LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".
a)_____mm Hg b)_____% c)____/____/____	6. If greater than 4 LPM is prescribed, enter results of recent test taken on 4 LPM. This may be an (a) arterial blood gas PO2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).

ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56–59 OR OXYGEN SATURATION = 89 IN QUESTION 1

❑ Y ❑ N 7. Does the patient have dependent edema due to congestive heart failure?

❑ Y ❑ N 8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement.

❑ Y ❑ N 9. Does the patient have a hematocrit greater than 56%?

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 option ordered; (2) Suppliers charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option (see instructions on back)

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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space TYPE/ 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," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and 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 or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her Medicare ID as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
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.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. 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.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
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 treating practitioner.)**
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 patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician 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 drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, 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's 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.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.