



**CERTIFICATION OF MEDICAL NECESSITY FOR CUSTOM DURABLE MEDICAL EQUIPMENT
PT/OT EVALUATION REQUIRED**

(To include, but not limited to: BATH CHAIRS, GAIT TRAINERS, STANDING FRAMES, SPECIALTY WALKERS,
SIT-TO-STAND SYSTEMS, ECT.)

Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____	
Members Name: _____	Members Medicaid Number (Do <u>Not</u> List Mother's ID): _____
Patient DOB ____/____/____ Sex ____ HT. ____ (in) WT. ____ (lbs.)	
Suppliers Name: _____	Suppliers Address and Telephone Number: _____
Suppliers NPI Number: _____	_____
Physicians Name: _____	Physicians Address and Telephone Number: _____
Physicians NPI Number: _____	_____
HCPSC Code(s)	_____
Place of Service	_____

Primary Diagnosis _____ ICD-10 Diagnosis Code _____

Secondary Diagnoses supporting medical necessity: _____

ICD 10 Diagnosis Code(s) _____ Length of Need _____

PHYSICAL EXAMINATION:

Provide detailed results of the physical examination as it relates to the member's mobility needs, and any related needs for special accommodations, options or accessories.

Ambulatory Status	Is the member ambulatory? ☐ YES ☐ NO If yes, describe in detail:
Ability to Self-Propel	Does the member have the ability to self-propel? ☐ YES ☐ NO If no, does the member have a caregiver willing and able to assist in propelling? YES ☐ NO ☐
Endurance	Describe the member's level of endurance:
Neck and Head Control	Describe the member's ability to control their head and neck:
Trunk	Provide review of exam of the member's trunk:



Patient Name: _____ DOB: _____

Pelvis/Hips	Hips Provide review of exam of the member's pelvis/hips:
Upper Extremities:	Provide review of exam of the member's upper extremities:
Skin Integrity	Provide review of exam of member's skin integrity:

Describe the activities of daily living and associated environments in which the complex or custom equipment is required for use:

☐ Home (required for in-home ambulation) Percentage of time required _____

☐ School (member's enrolled in school either in-home or in the community):

Enrolled at _____ Hours per Day _____

☐ Community Use (school, physician visits, etc.) ☐ Other _____

Does the member have complex or custom equipment to this request issued during the following time frame?

a) The last 5 years for members over 21? ☐ YES ☐ NO

b) The last 3-5 years for members under 21? ☐ YES ☐ NO

EQUIPMENT ORDERED

Please provide the HCPCS code and the description of the item determined to be the most appropriate for the member in the tables below. Provide a detailed rationale of why this equipment was selected and why any available least costly alternative was not deemed appropriate, where one exists.

HCPCS	BASE

Describe the specific custom equipment that is most appropriate for this member and provide a detailed rational:

HCPCS	MODIFICATIONS, OPTIONS, ACCESSORIES



Patient Name: _____ DOB: _____

HCPCS CONTINUED:	MODIFICATIONS, OPTIONS, ACCESSORIES

Describe the specific **modifications, options, and accessories** that are most appropriate for this member and provide a detailed rationale:

Ordering Physician

I certify that the complex or custom durable medical equipment listed on this certificate is medically necessary for this member, and that I have had a face-to-face evaluation with this member to discuss and review the appropriateness of the device within the ten (10) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation ____/____/____ (Must have occurred within 304 days prior to the order date)

Physician's Signature _____ Date ____/____/____

Physical or Occupational Therapist (PT/OT)

The Physical or Occupational Therapist who performed the evaluation for this device must complete the following:

PT/OT Signature _____ Date ____/____/____

PT/OT Printed Name _____

PT/OT GA License Number _____ Expiration Date ____/____/____

Licensed DME Supplier

The NRRTS Member who completed the assessment of this member and made equipment recommendations in collaboration with the ordering physician and PT/OT must complete the following:

NRRTS Member Signature _____ Date ____/____/____

Printed Name of NRRTS Member _____

License/Certification # _____ Expiration Date ____/____/____

Attach a copy of license or certification with prior authorization request.

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.