ACTION: Final

ENACTED
Appendix
5101:3-10-22

DATE: 12/21/2007 9:37 AM

## Ohio Department of Job and Family Services

## Certificate of Medical Necessity/Prescription Mechanical Ventilators

Certification Type	$\square$ Initial	$\square$ Revised	□ Recert	ification		
Instructions: The Certificate of Medical Necessity (CMN) must be where indicated, before requests will be considered for prior author		under the Ohio Med	licaid Program. This form m	ust be completed and carry the proper signature,		
Name of consumer						
	Medicaid Billing#:					
Street address	City/State/Zip		Date of B	irth		
Street address	City/State/Zip		Date of B			
List other respiratory equipment in use			Previous (	lates of service		
Elst other respiratory equipment in use			Tievious	ates of service		
			PA # of p	revious approval		
Section A—Must be completed by prescriber Diagnosis(es) Include ICD-9 code and description						
Diagnosis(es) include 1eb-7 code and description						
D. Cl. d. d. d.		1				
Date of last examination by prescriber (must be within 30 days prior to first date of service)		Consumer ha	er has permanent tracheostomy $\square$ Yes $\square$ No			
Medical history (attach hospital discharge summary	(6 1, 11)					
Medical history (attach hospital discharge summary	, ii applicable)					
	T					
Ventilatory support requirements	Ventilator settings/parameters					
☐ Continuous ☐ Nocturnal only	O2 setting					
☐ Other, explain:						
Section B—Prescriber's Attestation and Signatu Prescriber's name (PRINTED)	re/Date					
Trescriber's fiame (TRINTED)						
I certify that I am the prescriber identified above. I certif attached documents signed and dated by me is true to the						
subject me to civil or criminal liability.						
Prescriber's signature			Date	Ohio Medicaid Legacy #		
				NPI #		
Section C—Must be completed by Licensed Resp			101 1 41 1			
Complete this section if the Licensed respiratory care professional services:	ie veninator was disper		ts first week:	ation request		
		5-7				
Date placed on ventilator	Date placed on ventilator		Home visits after the first week (at least monthly)			
$\square$ Yes $\square$ No Home evaluation prior to hospital discharge?		Dates: 1)				
☐ Yes ☐ No Home set up?		2)				
☐ Yes ☐ No In-home training provided to care gi	yers? 3) 4)					
If "yes", check all that apply: ☐ Ventilator operati	5)					
☐ Tracheostomy care ☐ Cleaning/sterilizing	6)					
technique		□ Vas	□ No. Is the comm	mor baing woonad?		
Section D—Respiratory Therapist Attestation a	nd Signature/Date	☐ Yes	☐ No Is the consu	mer being weaned?		
LRCP name (PRINTED)	na-orginature/Date					
, , , , ,						
I certify that I am the respiratory therapist identified abov	o I certify that the infor	mation I have con	nnloted in this cortificate	is of medical necessity and any		
information on any attached documents signed and dated						
material fact may subject me to civil or criminal liability.  LRCP signature		Da	ta	License #		
LINET SIGNALUIC		Da	ic	License #		

JFS 01902 (Rev. 6/2007)

## Ohio Department of Job and Family Services

Certificate of Medical Necessity/Prescription IPPV or APAP in lieu of a Volume Ventilator									
Certification Type:	☐ Initial		evised		□ Recert				
Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.									
Name of consumer:		Medicaid Billing#:							
Street address:		City/State/Zip:			Date of Birth				
					/				
List other respiratory ed		er							
Section A—Must be completed by prescriber Diagnosis(es) Include ICD-9 code and description:									
Date of last examination by prescriber: / (must be within 30 days prior to first date of service)			□ Yes [	Yes $\square$ No Consumer has permanent tracheostomy					
	hospital discharge sumn		cable)						
☐ APAP or ☐ IPPV device is required for ventilatory support/only effective alternative to a volume ventilator		Length of need: ☐ Short term, # of months:							
			ettinas/r	☐ Chronic/permanent tings/parameters:					
	Nocturnal only								
O2 setting:									
Prescriber's name (PRIN	NTED):								
medical necessity and a	ny information on any at	tached docur	nents sig	ned ar	nd dated by me material fact r	npleted in this certificate is of is true to the best of my nay subject me to civil or  Ohio Medicaid Legacy #:			
Section B—Must be co	ampleted by Licensed	Pospirator	, Caro B	rofos	// sional (LPCP)	NPI #:			
Complete this	section if the ventilator	was dispens	ed prior	to sub	mitting prior a	uthorization request			
			Home	Home visits first week:					
Date placed on ventilator:/			☐ 5-7 ☐ 3-4 ☐ 1-2  Home visits after the first week (at least monthly)						
☐ Yes ☐ No Home evaluation prior to hospital discharge?			Dates: 1) / /						
☐ Yes ☐ No Home set up?		Bates	ź)//						
☐ Yes ☐ No In-home training provided to care givers?		3)//_							
If "yes", check all that apply: ☐ Ventilator operation			5)/						
☐ Tracheostomy care ☐ Cleaning/sterilizing			6)	/	/				
technique		□ Ye	☐ Yes ☐ No Is the consumer being weaned?						
LRCP name (PRINTED)									
I certify that I am the respiratory therapist identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.									
LRCP signature:	-			Date:		License #:			
				,	/ /				