Ohio Department of Job and Family Services

Certificate of Medical Necessity/Prescription
External Infusion Pump

SECTION A: Consumer/Provider Information

Certification Type: ☐ **Initial** ☐ **Revised** ☐ **Recertification**			
Consumer Name:		Provider's Name:	
Consumer DOB:	Consumer Sex: ☐ Female ☐ Male	Consumer HT (in.):	Consumer WT (lbs.):
(If consumer is not residing at home address) Facility Name:		Prescriber's Name:	
		Prescriber's Address:	
Facility Address:		Prescriber's Telephone:	
Facility City, State and Zip Code:		Prescriber's Medicaid Number:	

SECTION B: Information below may not be completed by the provider of the Items/Supplies

Est. Length of Need (# of Months): 1-99 (99=**LIFETIME**)	Diagnosis Codes (ICD-9) and Descriptions:
Last Consumer Medical Examination (MM/DD/YR):	

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)
☐ 1 ☐ 2 ☐ 3	1. Check number of pump which has been prescribed: 1- External infusion pump (non-disposable); 2- Implantable infusion pump; 3- Disposable infusion pump (e.g.,elastomeric)
HCPCS CODE: _____	2. Provide the HCPCS code and description for the drug that requires the use of the pump. Description:
_____	3. If non-specific code was used to answer questions, print name of drug below:
☐ 1 ☐ 2 ☐ 3	4. Check a number for method for route of administration? 1- Intravenous; 2- Epidural; 3- Subcutaneous
☐ 1 ☐ 2 ☐ 3	5. Check 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	7. Does the consumer have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PRESCRIBER (Please Print):
NAME: TITLE: EMPLOYER:

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Providers charge; and (3) Medicaid Fee Schedule Allowance for each item, accessory, and option.

I certify that I am the prescriber identified above. I certify that the information on this certificate 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 my falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature:	Date:

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