ACTION: Original

DATE: 04/27/2018 8:54 AM

Original RESCINDED Ohio Department of Medicaid CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION IPPV OR APAP IN LIEU OF A VOLUME VENTILATOR

Cer	tification Type:	☐ Initial		□ R	evised	☐ Rece	rtification		
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	<u>;</u> #		
Street address			City/State	/Zip				Date of birth	
List other respiratory equipment	t in use								
Section A—Must be complete	d by prescriber								
Diagnosis(es) Include ICD-9 co									
Date of last examination by prescriber (must be within 30 days prior to first date of service)				Consumer has permanent tracheostomy Yes No					
Medical history (attach hospital	discharge summary	, if applicable)		·					
APAP or IPPV device is required for ventilatory support/only effective alternative to a volume ventilate.				ator	Length	gth of need Short term, # of months Chronic/permanent			
Ventilatory support requirements Continuous Nocturnal only Other, explain: Ventilatory O2 setting				or settings/parameters					
Prescriber's name (PRINTED)									
I certify that I am the prescriber 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.									
Prescriber's signature					Date	e		edicaid Legacy	#
							NPI#		
Section B—Must be completed by Licensed Respiratory Care Professional (LRCP) Complete this section if the ventilator was dispensed prior to submitting prior authorization request									
Complete this section if the ventilator was dispensed prior to submitting prior authorization request Licensed respiratory care professional services Home visits first week									
				□ 5-7 □ 3-4 □1-2					
Date placed on ventilator				Home visits after the first week (at least monthly)					
☐ Yes ☐ No Home evaluation prior to hospital discharge? ☐ Yes ☐ No Home set up?				Dates: 1) 2)					
	training provided to	care givers?			3)				
If "yes", check all that apply:				4) 5)					
☐ Ventilator operation				6)					
Tracheostomy care				Is the	consume	r being weaned?	∏Yes	□No	
Cleaning/sterilizing technique				15 the	consume	r 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 #	‡	