Department of Health Care Services

State of California - Health and Human Services Agency CERTIFICATE OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT (DME)

(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

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	TION 1—Clinici n Name <i>(Print</i>)	an's Information:	First	Phone Number		License Number
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ddress		Street		City	State	ZIP
Clinic	cian's descriptio	n of the patient's cur	rrent function	al status and need for th	e requested equipr	nent:
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				Renewal, please also comple		Madi Oal Novebar
atient f	Name (<i>Print</i>)	Last	First	Phone Number ()	Date of Birth mm / de	
ddress	i	Street		City	State	ZIP
 Date	of last face-to-t	face visit with the bei	neficiary:			
s this	s beneficiary ex	spected to be instituti	ionalized with	nin the next 10 months?	Yes 🗍 No 🗍 E	xplain "Yes" answer: _
	oment required		NR for a renta	af)		
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Diagnoses:	Date of onset:
Prognosis:	
SECTION 5—Pertine	ent History:
SECTION 6—Function	onal Status:
Beneficiary's height:	Beneficiary's weight: Independent □ Walker/Cane □ Assisted □ Unassisted □ Unable □ Bed confined □
a) Ambulation:	Recent fall(s) Dizziness/Vertigo Incoordination Ataxia Severe shortness of breath
b) Transfer:	Self □ Self, but with great difficulty □ Self with a transfer device □
,	Stand by assistant With assistance Mechanical or person lift
c) Pertinent physic	cal findings: Edema (location):
	Pressure sore(s), state and location: Amputee ☐ Cast ☐ Ataxia ☐
-	(location): Sitting Posture/Deformity:
-	Vision: Impaired ☐ Normal ☐
Contractures:	
SECTION 7—Living	Environment:
	☐ Apartment☐ Stairs☐ Elevator☐ Ramp☐ Hills☐ SNF☐ ICF/DD☐ B&C☐
Other:	
ŭ	Lives alone ☐ With other person(s) ☐ Alone most of the day ☐ Alone at night ☐
	ive in attendant 🗖 or Hours/day Homemaker 🗇 Hours
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