Medicaid

Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

Pressure Reducing Surfaces	
Section A	
Patient Name, Address, Telephone Number, and Date of Birth	Physician Name, Address, and Telephone Number
Medicaid ID Number	NPI Number
Diagnosis (List the stage, location, size, depth, and type of drainage for all pressure ulcers.)	
Prognosis	
Treatment Plan	
Previous Treatment Plan	
Date of Last Evaluation by Physician	Physician's Name
Section B	
1. Can the patient reposition themselves? Yes No	
2. Does patient have coexisting pulmonary disease? Yes No	
3. Does the patient have a compromised circulation status? Yes No	
4. Does the patient have fecal or urinary incontinence?	□ No
5. Is patient bedridden? Yes If yes, how many hours? No	
6. Does the patient have a nutritional plan? Yes No	
 7. Narrative description of all items, accessories, sizes, and options, including model numbers to be included in this section. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document). Yes, additional attachments are included. 	
I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its	
attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.	
Signature and date stamps are not acceptable.	
Physician's Signature	Date (mm/dd/yyyy)

