OFFICE OF VERMONT HEALTH ACCESS – VERMONT MEDICAID
MEDICAL NECESSITY FORM (MNF)
ORTHOTICS, PROSTHETICS, MEDICAL SUPPLIES & EQUIPMENT FOR IN-HOME USE

All claims for supplies and equipment require a written physician order. Copies of the order must be kept in the patient record by both the physician and DME supplier. It is the responsibility of the ordering physician to complete or review this Medical Necessity Form (MNF) and provide adequate documentation/information of the plan of treatment. The physician then gives this information either to the patient (to be taken to the DME supplier of choice) or directly to the DME supplier. The DME supplier must be enrolled in Vermont Medicaid.

Section A: (must be completed or reviewed and signed by ordering physician)

1.Patient's Name_____ DOB___/___/___Medicaid ID#_____
Section A (must be completed or reviewed and signed by ordering physician)

2.Diagnoses_____

3.Place of service: Is(are) the ordered item(s) to be used in the patient's home? Yes___ No_____
Name and address of other facility_____

4.Functional Level (check all that apply): Ambulatory___Non-ambulatory___Bed-ridden___
Confined to wheelchair____Able to transfer self___Ambulatory with assistance___ assist of what/whom_____
Able to use regular bathroom facilities____if not, why?_____

5. HCPCs Code and Name of Item Ordered	Initial Order Date	Purpose or Use of Item	Expected Length of Need (months)	# Per Month

6.Date of Related Incident_____/_____/_____**Date of Related Surgery**_____/_____/_____

I CERTIFY THAT THE ITEM(S) PRESCRIBED ABOVE IS(ARE) A NECESSARY PART OF THE COURSE OF TREATMENT AND NOT FOR PRECAUTIONARY OR STANDBY PURPOSES NOR FOR CONVENIENCE OR COMFORT.

7.Physician's Name & Address_____

8.Physician's Signature_____**Date Signed**_____

9.Physician's Medicaid Provider #_____**Phone#**_____

Physician: Please give this form to the recipient or send directly to supplier. Do not send to the Office of Vermont Health Access or to EDS.

See back for DME information and instructions

Section B FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES (completed by the DME vendor)

9. Date equipment first placed in the home____/___/____

10. List equipment currently in home relevant to item(s) requested:	**Rented? (Yes or No)**

Signature of DME employee completing above information:_____ phone#_____
Medicaid DME provider #_____

The DME supplier must include a copy of this MNF with every Prior Authorization (PA) request. See the DME Provider Manual for procedure codes which require PA or a MNF to be submitted with the claim. Exceptions to this rule include certain prosthetics (ostomy supplies and those prostheses which replace a missing body part), urologic supplies and diabetic supplies. For these items, the MNF need only be kept in the patient record, not sent in with the claim.

For all items, the provider may attach a separate page with the treatment plan, PT or OT notes, explanation, and/or relevant progress notes.

INSTRUCTIONS FOR SECTIONS A & B

Section A must be completed or reviewed, **signed and dated by the ordering physician.**
Section B must be completed by the DME vendor when equipment and/or supplies are ordered

1. Patient's **first & last name, date of birth** (DOB) and **Medicaid ID number** (Social Security#).
2. Print all related **diagnoses**, including status diagnoses such as colostomy, tracheostomy. If this is an initial order or there have been significant clinical changes, attach documentation reflecting the physician's treatment plan.
3. Must answer yes or no. If no (if the ordered item is to be used in a **place of service** other than the patient's home(, the name and address of that facility is required.
4. Check all **functional levels** which apply (for **commodes**, an explanation is required as to why this patient cannot use regular bathroom facilities)
5. List each **item** being ordered, **date of the initial order, purpose** (for example, softwick sponges for tracheostomy or saline for open wound care), **expected length of need** (will be interpreted as months unless stated otherwise), and the **number of items needed** (eg, 60 softwick sponges per month, 2 bottles of sterile saline per month).
   NOTE: If the quantity ordered is more than the number allowed (based on customary usage and given in the DME Provider Manual), an explanation from the physician will be needed.
6. Whenever the item being ordered is related to a fracture, accident, congenital birth defect, etc. and/or when there has been related surgery, give the **date of that event and/or the date of surgery.**
7. Print the ordering/signing physician's **name, address** and **phone number** (must be legible).
8. This **signature** must be that of the ordering physician and attests to the validity of the information given. The **date** of this signature is also required. The physician's individual **Medicaid provider #** is necessary so the DME vendor can bill.
9. **To be completed by the DME** vendor: When the ordered item is equipment, rented or purchased, these two date fields are mandatory.
10. **To be completed by the DME vendor:** List all equipment now in the home for use for this patient (eg, suction machine, ventilator, oxygen concentrator, semi-electric bed, nebulizer, oxygen or compressed air tanks, wheelchair, walker, commode, etc...) and for each, state yes if it is being rented or no if it is not rented equipment.