

CERTIFICATE OF MEDICAL NECESSITY

EXTERNAL INFUSION PUMP

SECTION A

Certification Type/Date:

INITIAL ___/___/___

REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER

(____)____-____ HICN _____

(____)____-____ NSC # _____

PLACE OF SERVICE _____
NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE

PT DOB ___/___/___; Sex ___ (M/F); HT. ___(in.); WT. ___(lbs.)

PHYSICIAN NAME, ADDRESS (Printed or Typed)

PHYSICIAN'S UPIN: _____

PHYSICIAN'S TELEPHONE #: (____)____-____

SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

DIAGNOSIS CODES (ICD-9): _____

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 3 4

1. Circle number of pump which has been prescribed:
1 - External infusion pump (non-disposable); 2 - Reserved for other or future use;
3 - Implantable infusion pump; 4 - Disposable infusion pump (e.g., elastomeric)

HCPCS CODE:

2. Provide the HCPCS code for the drug that requires the use of the pump.

3. If non-specific code was used to answer questions, print name of drug.

1 3 4

4. Circle number for route of administration?
1 - Intravenous; 2 - Reserved for other or future use; 3 - Epidural; 4 - Subcutaneous

1 2 3

5. Circle 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 D

7. Does the patient 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 PHYSICIAN (Please Print):

NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See *Instructions On Back*)

SECTION D

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)