Name of Provider: _____
Provider NPI # _____
Provider Medicaid Legacy (Optional) # _____

Ohio Department of Job and Family Services

Certificate of Medical Necessity/Prescription

Incontinence Supplies

Instructions: The Certificate of Medical Necessity (CMN) must be used for incontinence garments and disposable supplies under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests which require prior authorization will be considered.

Name of Consumer:		Consumer Medicaid Number:
Street address:	City/State/Zip:	Date of Birth ____/____/_____

Section A

Diagnosis(es): Include ICD-9 codes (mandatory) and description (optional)

Supply Requested

Type of incontinence garment/disposable supply needed	# Needed per month X 12 months

Section B—Prescriber Attestation and Signature/Date

Prescriber Name (printed):	Date of last face to face examination of consumer:

I certify that I am the prescriber identified above. I certify that the information in Section A 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 signature: (No stamps)	Date: ___/___/___	Prescriber NPI #:

JFS 02912 (3/2011)