Affiliated Computer Services
Certificate of Medical Necessity, Page 1 of 2

Submitted by: _____

Date: _____

Recipient Name: _____ Medicaid #: _____ DOB (MM/DD/YY): _____ Age:_____ Sex: ____ (M or F)	Ordering Provider's Name: _____ Medicaid ID# or AK License #: _____ Telephone #: (___) _____ Ext. _____
HT: _____ (inches) WT: _____ (pounds) Date of last visit: _____	Retrospective Review? _____ (Y/N)

SECTION A: CLINICAL INFORMATION: *(This section **MUST** be completed by the attending physician, nurse practitioner, physician assistant or audiologist.)*

DIAGNOSIS	ICD-9-CM

Estimated Length of Need (# of Months): _____1 – 99 ***(99 = Lifetime)***

SECTION B: **CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN:** Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. *(This section may be completed by the attending specialist, including the physician, nurse practitioner, physician assistant, physical therapist, occupational therapist, speech language pathology therapist, registered dietitian, audiologist, or other attending specialist within the scope of his or her specialty.)*

PLAN: *The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.*

ATTESTATION, SIGNATURE AND DATE OF AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST (Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

A physician, nurse practitioner, physician assistant, audiologist or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____
Signature of Specialist – Title Date

This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.

_____ _____
Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant Date

I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.

Affiliated Computer Services, Inc.
Certificate of Medical Necessity, Page 2 of 2

Submitted by: _____

Date: _____

Recipient Name: _____

Medicaid #: _____

DOB (MM/DD/YY): _____ Age:_____ Sex: M (M or F)

Ordering Provider's Name: _____

Medicaid ID# or AK License #: _____

Telephone #: (___) _____ Ext. _____

SECTION C: REQUESTED SERVICES OR ITEMS: (*To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)*

Provider Name: _____

Address: _____

Provider Medicaid No.: _____

Requester Name: _____

Telephone #: (_____) _____ Ext. _____

Fax #: (_____) _____ Ext. _____

Dates of Need – Start Date: _____ **End Date:** _____

ACS Use Only

Your request is:

☐ Approved as requested

☐ Approved as modified
(Items marked as authorized may be claimed.)

Prior Authorization Number:
_____

From Date: _____ Thru Date: _____

☐ Denied

Authorizing Agent Signature & Date:

Comments:

	Procedure Code	Mod.	Description	QTY (#)	Charges	Authorized Yes	Authorized No	Approved Quantity	Approved Amount
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									

SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

_____ Signature of Supplier

_____ Date