



**DURABLE MEDICAL EQUIPMENT REQUEST FORM**

Form must be *submitted with medical records* to support services. Please email all forms and documents to the address listed above.

**NOTE: ALL FIELDS ARE REQUIRED**

Date:	
<b>GENERAL INFORMATION</b>	
Durable Medical Equipment:	
First Date of Service:	Last Date of Service:
Primary Diagnosis Code:	Secondary Diagnosis Code(s):
Procedure Code(s):	Quantity:
Procedure Description:	
<b>RECIPIENT INFORMATION</b>	
Medicaid ID: (9 digits)	Date of Birth:                      Sex:    M    F
Last Name:	First Name:
<b>PROVIDER INFORMATION</b>	
Referring Provider Name:	
Address:	
Point of Contact Name and Title:	
Email:	Phone:
<i>Note: The determination notice will be sent to the listed Point of Contact.</i>	
Servicing Provider Name:	
Servicing Provider NPI:	Servicing Provider Taxonomy:
Email:	Phone:

# Certificate of Medical Necessity

RECIPIENT NAME: \_\_\_\_\_ Date of Birth \_\_\_\_\_

MEDICAID ID NUMBER: \_\_\_\_\_

**DIAGNOSIS** - Including an explanation of the particular problem resulting from the diagnosis which relates to this equipment request (if O<sub>2</sub> is being prescribed please include the results of the most recent test, the condition of the test- at rest, during exercise or during sleep):

**PROGNOSIS:**

**EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR CONTINUED RENTAL:**

**OXYGEN PRESCRIPTIONS ONLY:**

**STATIONARY**            **PORTABLE** (if portable the recipient must be mobile within their home)

**HOW LONG IS THIS CONDITION EXPECTED TO LAST?**

**MONTHS** \_\_\_\_\_ **INDEFINITELY**            **PERMANENTLY**

**EQUIPMENT BEING PRESCRIBED; INCLUDING CPT CODE/S:**

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S NPI: \_\_\_\_\_

EXPLANATION OF THE EQUIPMENT'S FUNCTION:

MANUFACTURER:

EQUIPMENT SERIAL #:

EQUIPMENT STATUS:      NEW RENTAL

CONTINUOUS RENTAL

PURCHASE

REPAIR

PURCHASE PRICE: \$

RENTAL PRICE (Per month price): \$

DME PROVIDER NAME:

DME PROVIDER'S NPI:

DME PROVIDER MAILING ADDRESS:

DME CONTACT NUMBER:

DME Email:

DME PROVIDER'S CONTACT NAME:

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The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre SD 57501, 605-773-3305.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).