South Dakota Department of Social Services

Certificate of Medical Necessity

Date:		
RECIPIENT INFORMATION		
Medicaid ID: (9 digits)	**Date of Birth:** ___/____/____	**Sex:** ☐ M ☐ F
First Name:	**Last Name:**	
PRESCRIBING PROVIDER INFORMATION		
Provider Name:		
Provider Signature:	**Date:**	
Provider NPI:	**Provider Taxonomy:**	
Provider Mailing Address:		
Fax:	**Phone:**	
GENERAL MEDICAL INFORMATION		
Start Date of Service: ___/___/____	**End Date of Service:** ___/___/____ ☐ **Indefinitely**	
Primary Diagnosis Code:	**Secondary Diagnosis Code(s):**	

Diagnosis, Prognosis, and Medical Necessity: Provide a description of the condition/diagnosis, prognosis, and a justification of the medical necessity of the equipment. If oxygen is being prescribed please include the results of the most recent test, the condition of the test- at rest, during exercise or during sleep.

DME PROVIDER INFORMATION			
Provider Name:			
Provider NPI:	**Provider Taxonomy:**		
Provider Mailing Address:			
Fax:	**Phone:**		
SUPPLIES/EQUIPMENT INFORMATION			

Description and Function of Supplies/Equipment: (must include HCPCS)

Estimated number of Units:		**Price per unit:**	

Oxygen Prescription Only: ☐ **Stationary** ☐ **Portable** (The recipient must be mobile within their home)

Manufacturer:

Equipment Serial Number:

Equipment Status: ☐ **Purchase** ☐ **Repair** ☐ **New Rental** ☐ **Used Rental** ☐ **New Continuous Rental** ☐ **Used Continuous Rental**

Attachments N☐ Y☐ Number of Attachments:_____

This form meets the requirements for South Dakota Medicaid found in ARSD 67:16:29:04.02. Revised April 2020