CONDUENT

| MEMBER INFORMATION | PROVIDER INFORMATION |
|---|---|
| Member Name: _____ *(Last, First, MI)* | Ordering Provider's Name: _____ |
| Alaska Medicaid Member ID: _____ | Provider Medicaid ID or NPI: _____ |
| Date of Birth *(MM/DD/YY)*: _____ Age:_____ Sex: _____ | Phone Number: _____ Ext. _____ |
| *Height: _____ *(inches)* *****Weight: _____ *(pounds)* | Prescription Start Date: _____ |
| Date of last visit: _____ | Retrospective Review? ○ Yes ○ No |

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

| | Diagnosis Code | Diagnosis Description |
|---|---|---|
| **ICD-10** | | |

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

**SECTION B - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN**

Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Attach any supporting documentation as needed for further justification. *(This section may be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.)*

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

## **Daily** Usage Supplies *(mark appropriate quantity)*:

| | | |
|---|---|---|
| Disposable Brief / Undergarment | ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 | Other Qty ____* |
| Insert Pads *(used in briefs)* | ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 | Other Qty ____* |
| Disposable Bed Pads | ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 | Other Qty ____* |

* If "Other Qty" is completed, you must provide additional medical justification for the higher quantity requested.

** 1 Unit = One container *(bottle, tube, etc.)* regardless of size or volume.

*** ***Note to Supplier:*** If the packaging quantity is not the same as the 100/200/300/400/500 quantity circled, you may round to the nearest size packaging to avoid breaking open a package.

## **Monthly** Usage Supplies *(mark appropriate quantity)*:

| | | |
|---|---|---|
| Reusable Bed Pads w/ or w/o Flaps | ○ 1 ○ 2 ○ 3 ○ 4 | Other Qty ____* |
| Gloves *(per month)* | ○ 100 ○ 200 ○ 300 ○ 400 | Other Qty ____* |
| Moisture Barrier Ointment/Gel** | ○ 1 ○ 2 ○ 3 ○ 4 | Other Qty ____* |
| Moisture Barrier Cream** | ○ 1 ○ 2 ○ 3 ○ 4 | Other Qty ____* |
| Moisture Barrier Lotion** | ○ 1 ○ 2 ○ 3 ○ 4 | Other Qty ____* |
| Protectant Powder** | ○ 1 ○ 2 ○ 3 ○ 4 | Other Qty ____* |
| Skin Cleanser** | ○ 1 ○ 2 ○ 3 ○ 4 | Other Qty ____* |
| Disposable Wipes *(each)**** | ○ 100 ○ 200 ○ 300 ○ 400 ○ 500 | Other Qty ____* |
| Disposable Wash Cloths *(each)**** | ○ 100 ○ 200 ○ 300 ○ 400 ○ 500 | Other Qty ____* |

**NOTE: These supplies are for incontinence treatment only and not for treatment of other areas of the body.**

**ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN/ PHYSICIAN ASSISTANT/NURSE PRACTITIONER**

*A physician, physician assistant, or nurse practitioner who attests to the medical necessity and quantity 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.*

*I hereby certify that I am the ordering physician, physician assistant, or nurse practitioner identified in this form.*

_____ _____

Signature of Physician / Physician Assistant / Nurse Practitioner Date