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 related to incontinence: _____ | |

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

| | Diagnosis Code | Diagnosis Description |
|---|---|---|
| **ICD-10** | | |
| | **Include ALL diagnoses to include the type of incontinence and the cause of the incontinence at a minimum.** | |

**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 only be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.)*

**Questions 1-7 below must be completed.**

1. Is the individual at least three years of age and under 10 years of age and do medical records document that the recipient has not responded to, would not benefit from, or has failed bowel or bladder training? ☐ Yes ☐ No ☐ N/A
2. What is the individual's frequency of incontinence?
3. Provide a description of the individual's ability to manage incontinence independently or with assistance.
4. What is the individual's prognosis for controlling incontinence?
5. What is the individual's level of skin integrity and vulnerability to skin breakdown?
6. Is the individual prescribed diuretics or other medications that increase output? ☐ Yes ☐ No
7. Does the individual have any allergies to known product materials? ☐ Yes ☐ No

**Provide additional medical justification**, as it pertains to the member's specific diagnoses, indicating the medical necessity of the requested items. Attach any supporting documentation as needed. If requests are made for greater than current maximum quantities of items, additional medical justification **MUST** be submitted with this form to justify the need for greater than maximum quantities. Please see quantities listed on page 2 of the Certificate of Medical Necessity for Incontinence Supplies Instructions.

Service authorization approval does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.

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. _____ |

**PLAN:** *The plan should list each service or item specifically needed for the treatment of the member. Attach additional treatment information.* ***If "Other Qty" is completed****, you must provide* ***additional medical justification*** *for the higher quantity requested.*

***** Please see current max quantity limits under the Certificate of Medical Necessity for Incontinence Supplies Instructions, page 2. For quantities requested under 'Other Qty' sections below, additional medical justification MUST be submitted with this form to justify the need for greater than maximum quantities.***

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

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

**Quarterly** Usage Supplies *(mark appropriate quantity)*:

Reusable Bed Pads w/ or w/o Flaps ○ 1 ○ 2 ○ 3 ○ 4

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

| | | |
|---|---|---|
| Gloves *(per month)* | ○ 100 ○ 200 ○ 300 ○ 400 | Other Qty _____ |
| Disposable Wipes *(each)* | ○ 100 ○ 200 ○ 300 ○ 400 ○ 500 | Other Qty _____ |
| Disposable Wash Cloths *(each)* | ○ 100 ○ 200 ○ 300 ○ 400 ○ 500 | Other Qty _____ |

*May be based on recipient preference of up to 1000 wipes or 1000 wash cloths without requiring an updated prescription/CMN form.

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

**Monthly** Skincare Supplies *(mark appropriate quantity)*: 1 Unit = One container *(bottle, tube, etc.)* regardless of size or volume.

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

***Current utilization requirements limit the following supplies to no more than 2 bottles, containers, etc. of any one product per month or combination of products. Requests for more than a total 2 products per month, regardless of the type of product or combination of products, will not be approved.***

***Choose only ONE (1) Option below***

- ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream
- **OR** ☐ 2 bottles Moisture barrier lotion/ointment/gel/cream
- **OR** ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream AND 1 bottle Protectant Powder
- **OR** ☐ 1 bottle Moisture barrier lotion/ointment/gel/cream AND 1 bottle Skin Cleanser
- **OR** ☐ 1 bottle Protectant Powder AND 1 bottle Skin Cleanser
- **OR** ☐ 1 bottle Protectant Powder
- **OR** ☐ 2 bottles Protectant Powder
- **OR** ☐ 1 bottle Skin Cleanser
- **OR** ☐ 2 bottles Skin Cleanser

**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

Service authorization approval does not guarantee payment. Payment is subject to member's eligibility. Be sure the identification card is current before rendering services.