



MEMBER INFORMATION	PROVIDER INFORMATION
Member Name: _____ <i>(Last, First, MI)</i>	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.



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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):	Monthly Usage Supplies (mark appropriate quantity):
Disposable Brief / Undergarment 1 2 3 4 5 6 Other Qty _____	Gloves (per month) 100 200 300 400 Other Qty _____
Insert Pads (used in briefs) 1 2 3 4 5 6 Other Qty _____	Disposable Wipes (each) 100 200 300 400 500 Other Qty _____
Disposable Bed Pads 1 2 3 4 Other Qty _____	Disposable Wash Cloths (each) 100 200 300 400 500 Other Qty _____
Quarterly Usage Supplies (mark appropriate quantity):	<p>*May be based on recipient preference of up to 1000 wipes or 1000 wash cloths without requiring an updated prescription/CMN form.</p> <p>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.</p>
Reusable Bed Pads w/ or w/o Flaps 1 2 3 4	

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



Certificate of Medical Necessity for Incontinence Supplies Instructions

Submission Requirements: This Certificate of Medical Necessity (CMN) for Incontinence Supplies must be completed to request services and must bear the signatures of the professionals who, by signing the form, attest that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements. **Submit all CMN requests directly to Conduent, the fiscal agent,** by fax at 907.644.8131 or by mail at Conduent Service Authorization, PO Box 240808, Anchorage, AK 99524-0808.

Submitted by: Enter the name of the individual submitting the CMN.

Date: Enter the date the CMN is completed.

Member Information *This information is auto-filled on the 2nd page.*

Member Name: Enter the member's last name, first name, and middle initial.

Alaska Medicaid Member ID: Enter the Alaska Medicaid Member ID number.

Date of Birth: Enter the member's date of birth using the calendar feature or a MM/DD/YY format.

Age: Enter the age of the member.

Sex: Select the gender of the member.

***Height:** Enter the member's height in inches.

***Weight:** Enter the member's weight in pounds.

Note: *Certain services/items cannot be approved without height and weight.*

Date of Last Visit: Enter the date of the member's last visit using the calendar feature or a MM/DD/YY format.

Provider Information *This information is auto-filled on the 2nd page.*

Ordering Provider's Name: Enter the ordering provider's last name, first name, and middle initial.

Provider Medicaid ID or NPI: Enter the ordering provider's Medicaid ID or NPI number.

Phone Number & Ext.: Enter the ordering provider's contact phone number and extension.

Prescription Start Date: Enter the requested prescription start date using the calendar feature or a MM/DD/YY format.

Retrospective Review?: Check 'Yes' or 'No'.

Section A – Clinical Information

Note: *This section **must** be completed by the attending physician, physician assistant, or nurse practitioner.*

Diagnosis Code (ICD-10): Enter the primary ICD-10 diagnosis code, at a minimum, for the requested services.

Diagnosis Description (ICD-10): Enter the corresponding description for each ICD-10 diagnosis code entered.

Estimated Length of Need: Enter the number of months the requested services or items will be needed. Enter '99' in this field if the services or items requested are needed on a continuous basis for the member's lifetime.

Note: *Entering a lifetime span does not guarantee payment to the provider for these services or items for the member's lifetime. Medical justification must support the request and the member must meet eligibility requirements for the duration of the authorization. Additionally, lifetime requests are subject to a periodic recertification to ensure medical necessity.*

Section B – Clinical Assessment of Need for Prescribed Services or Item(s) and Plan

Note: *This section may be completed by the attending physician, physician assistant, or nurse practitioner within the scope of his or her specialty.*

Clinical Assessment of Need for Prescribed Service(s) or Item(s): Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. The member's specific medical condition causing the incontinence must be included in the justification. Medical justification must be complete and thorough in order to process the request. Attach additional supporting documentation as needed for further justification.

Plan: The plan should list each item specifically needed, based on a daily or monthly usage, for the treatment of the member. Attach a detailed treatment plan or other pertinent information as needed.

Attestation, Signature, and Date of Physician/Physician Assistant/Nurse Practitioner: Enter signature of the physician/physician assistant/nurse practitioner submitting the CMN request and date signed. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.



Certificate of Medical Necessity for Incontinence Supplies Instructions (Cont)

Section C – Requested Services or Items

Provider Name: Enter the supplying provider’s last name, first name, and middle initial.

Address: Enter the address of the supplying provider.

Provider Medicaid ID or NPI: Enter the supplying provider’s Medicaid ID or NPI number.

Requester Name: Enter the name of the requesting individual.

Phone Number & Ext.: Enter the supplying provider’s contact phone number and extension.

Fax Number & Ext.: Enter the supplying provider’s fax number and extension, if applicable.

Dates of Need – Start Date / End Date: Enter the start date and end date of the authorization.

Procedure/Drug Code: Enter the procedure/drug code for the service or item requested.

MOD: Enter any applicable modifier codes for the requested service or item.

Description: Enter the description of the requested service or item.

Qty: Enter the quantity of the service to be performed or item to be dispensed.

Charges: Enter the total estimated charges for the requested service or item.

Section D – Supplier Attestation, Signature, and Date: Enter signature and title of the supplying professional submitting the CMN request. The signature must be that of the professional who, by signing the form, attests that the content of the completed form is accurate and meets Alaska Medical Assistance program requirements.

Certificate of Medical Necessity for Incontinence Supplies Amendments

Any changes to an approved CMN or requests for additional services or items must be requested through the Conduent Service Authorization department. All changes to any field(s) on the approved form must be initialed and dated by the original prescribing medical provider. Additionally, supporting medical documentation justifying medical necessity must accompany any requests for additional services or items.

Maximum Quantities for Incontinence Supplies as of 01/01/2020:

ADULT SIZE BRIEF	180	Per Month
ADULT SIZE PULL-ON	180	Per Month
PED SIZE BRIEF/DIAPER	180	Per Month
PED SIZE PULL-ON	180	Per Month
YOUTH SIZE BRIEF/DIAPER	180	Per Month
YOUTH SIZE PULL-ON	180	Per Month
DISPOSABLE LINER/SHIELD/PAD	200	Per Month
DISPOSABLE UNDERPAD	120	Per Month
REUSABLE UNDERPAD	4	Per 3 Months

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