ALASKA MEDICAID
CERTIFICATE OF MEDICAL NECESSITY, GENERAL
PRESCRIBER PAGE

SECTION A **PRESCRIBER INFORMATION**	**MEMBER INFORMATION**
Prescriber Name: _____	Member Name:_____
Provider Medicaid ID or NPI: _____	Member Medicaid ID: _____
Phone Number: _____	DOB:_____ Gender: _____
Fax Number:_____	Height (inches): _____ Weight: _____
	Phone Number: _____

SECTION B No information in the following sections may be completed by the DME supplier.

Date of last visit related to request: _____ Prescription Start Date: _____

Est. Length of Need: (1-99 months, 99 = lifetime) _____

	Diagnosis Code	Description
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

SECTION C - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICE(S) 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 specialist, including the physician, physician assistant, nurse practitioner, physical therapist, occupational therapist, speech language pathology therapist, registered dietitian, audiologist, or other attending specialist 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.*

ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN/ PHYSICIAN ASSISTANT/NURSE PRACTITIONER/ AUDIOLOGIST AND SPECIALIST

(Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

A physician, physician assistant, nurse practitioner, audiologist or specialist who attests to the medical necessity 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.

This must be signed by the specialist if Section C is completed by someone other than the provider in Section A.

_____ _____

Signature of Specialist, Title Date

I hereby certify that I am the ordering physician/physician assistant/nurse practitioner/audiologist identified in this form.

_____ _____

Signature of Physician / Physician Assistant / Nurse Practitioner / Audiologist Date