

**SECTION A: (To be completed by the supplier)**

- CERTIFICATION TYPE:** Check the appropriate box to indicate if this CMN is the initial certification for this patient or if this is a revised certification.
- BENEFICIARY INFORMATION:** Indicate the beneficiary's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on the beneficiary's Medicare card and on your claim form.
- PLACE OF SERVICE:** Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to your supplier manual for a complete index.
- REPLACEMENT:** If the item billed is a replacement for a previously purchased item, place a check mark in the blank.
- FACILITY NAME:** If the place of service is a facility, indicate the name and complete address of the facility.
- SUPPLIER INFORMATION:** Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
- HCPCS CODES:** List all procedure codes for items ordered that require a CMN. Procedure codes that do not require a certification should not be listed on the CMN. If the item ordered is purchased equipment, indicate whether the equipment is covered by a warranty. "Y" denotes that there is a warranty and "N" indicates there is no warranty. If it is covered by a warranty, the length and type of warranty must be indicated.

**SECTION B: (To be completed by the physician or physician's employee)**

- DIAGNOSIS:** In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3).
- EXAMINATION DATE:** Indicate the date (MM/DD/YY) the patient was last seen by the ordering physician prior to the beginning of this certification period.
- PT. HT., PT. WT., DOB:** Indicate the patient's height in inches and weight in pounds (when required by individual policy). Indicate patient's date of birth (MM/DD/YY).
- DATE NEEDED:** Indicate the date (MM/DD/YY) the ordered item was initially needed outside the hospital setting. If this certification is a revised certification, also indicate the effective date of the order change.
- EST. LENGTH OF NEED:** Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
- QUESTION SECTION:** This section is used to gather clinical information to determine medical necessity. Answer each question within the category of the items ordered, using "Y" for yes, "N" for no, and "D" for does not apply, unless otherwise noted.
- PHYSICIAN INFORMATION:** The physician's signature certifies that the item ordered is medically necessary for this patient and that section B was completed or reviewed by the physician. This form must be signed and dated by the physician. Signature and date stamps are not acceptable.
- The physician must indicate whether he/she is the attending, consulting or other ordering physician by putting a check mark in the appropriate box. Indicate other ordering when you are neither the attending or consulting physician. Refer to your supplier manual for more information.
- PHYSICIAN NAME, ADDRESS:** Indicate physician's name and complete mailing address.
- UPIN:** The physician must indicate his/her Unique Physician Identification Number (UPIN).
- PHYSICIAN'S TELEPHONE NO:** The physician must give a telephone number where he/she can be contacted (preferably a number where records would be accessible pertaining to this patient) if more information is needed.