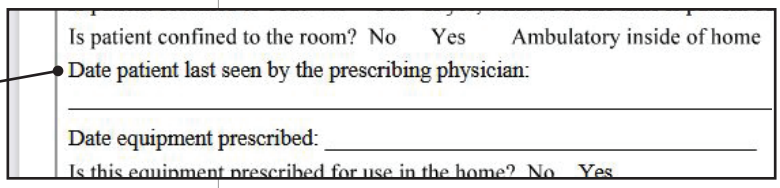
CMN for KY - helpful tips!

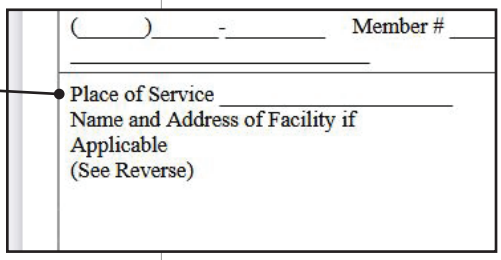
To help you expedite the funding paperwork faster for Kentucky, including this Certificate of Medical Necessity form, Forbes AAC would like to share a few tips to make this process more efficient.

All of us know accuracy, details and being complete are the keys to the CMN form and it being approved quickly- please follow these brief tips for a faster run through the Funding Department.

1. Make sure the '**last seen by prescribing physician:**' date is BEFORE the next line, '**equipment prescribed:**' and be sure that they are within sixty (60) days of each other.

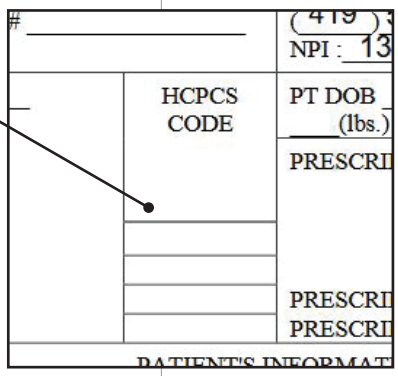


2. The correct answer for the '**Place of Service**' should be "***HOME***", not 'at house' or 'Doctor's office', for example.



3. Make sure the '**INITIAL**' or Initial Intake (top of form) is dated ***before*** the date of '**equipment prescribed:**' further down the first page.

4. In this box, make sure the necessary products codes are in place - **E2510= Speech Device, E2599= all accessories, E2512= mounting system and mount plate**



If you have any questions or need assistance, please contact Funding at **419.589.7688** ***option*** **5**.

CERTIFICATE OF MEDICAL NECESSITY
Cabinet for Health & Family Services
Department of Medicaid Service
Durable Medical Equipment

SECTION A Certification Type/Date INITIAL ____/____/____ REVISED
____/____/____

Patient Name, Address, Telephone and Member Number

(_____)_____-_____ Member # _____
_____

Supplier Name, Address, Telephone and ~~NSC~~ NPI Number

Forbes Rehab Services, Inc.
49 S. Illinois Avenue, Mansfield, OH 44905

(419) 589 - 7688 ~~NSC#~~
NPI : 1346326220

Place of Service _____
Name and Address of Facility if Applicable
(See Reverse)

HCPCS CODE

PT DOB ____/____/____; Sex ____(M/F); HT. ____(in.); WT. ____(lbs.)

PRESCRIBER NAME, ADDRESS (Printed or Typed)

PRESCRIBER NPI:_____

PRESCRIBER TELEPHONE #: (_____)_____-_____

SECTION B PATIENT'S INFORMATION

(Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.)

Est. Length of Need (# of Months): _____ 1-99 (99=Lifetime)

DIAGNOSIS WITH CODES, PROGNOSIS, GENERAL CONDITION:

Type of equipment ordered:

Duration of need: _____ month(s) Over 12 mos.: specify _____

Is patient confined to bed? No ☐ Yes ☐ If yes, what % of the time is patient confined to the bed? ☐ 50% ☐ 75% ☐ 100%

Is patient confined to the room? No ☐ Yes ☐ Ambulatory inside of home ☐ Ambulatory outside of home ☐

Date patient last seen by the prescribing physician:

Date equipment prescribed:

Is this equipment prescribed for use in the home? No ☐ Yes ☐

Is patient disoriented? No ☐ Yes, occasionally ☐ Yes, most of the time ☐

Is patient able to effectively and safely utilize equipment unassisted? No ☐ Yes ☐

Name of person answering Section B questions, if other than physician (Please Print)

Name:_____ Title: _____ Employer:_____

CERTIFICATE OF MEDICAL NECESSITY
Department of Medicaid Service
Durable Medical Equipment

SECTION C	Narrative Description of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option.

SECTION D	Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability

PHYSICIAN'S SIGNATURE _____ DATE ____/____/_____ (Signature And Date Stamps Are Not Acceptable)