DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0679

DME MAC 04.04C

CERTIFICATE OF MEDICAL NECESSITY
CMS-847 — OSTEOGENESIS STIMULATORS

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or applicable NPI NUMBER/LEGACY NUMBER
(___) ___ ___ ___ ___ HICN _____	(___) ___ ___ ___ ___ NSC or NPI # : _____
PLACE OF SERVICE 12	SUPPLY ITEM / PROCEDURE CODE: E0748NU	PT DOB ___/___/___ Sex ___ (M/F) Ht. ___ (in) Wt ___ (lbs.)
NAME and ADDRESS of FACILITY if applicable (see reverse)		PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI NUMBER or UPIN
		(___) ___ ___ ___ ___ UPIN or NPI # _

SECTION B **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 CODES: _____ _____ _____ _____

ANSWERS	QUESTIONS 1-5 ARE BLANK. ANSWER QUESTIONS 6-8 FOR NONSPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 9-11 FOR SPINAL ELECTRICAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 6 and 12 FOR ULTRASONIC OSTEOGENESIS STIMULATOR. (Circle Y for Yes, N for No, or D for Does Not Apply. For questions about months, enter 1-99 or D. If less than one month, enter 1.)
a) Y N D	6. In a fracture, has there been no clinically significant radiographic evidence of healing for a minimum of 90 days?
a) Y N D b) _____	7. (a) Does the patient have a failed fusion of a joint other than the spine? (b) How many months prior to ordering the device did the patient have the fusion?
Y N D	8. Does the patient have a congenital pseudoarthrosis?
a) Y N D b) _____	9. (a) Is the device being ordered as a treatment of a failed single level spinal fusion surgery in a patient who has not had a recent repeat fusion? (b) How many months prior to ordering the device did the patient have the fusion?
a) Y N D b) _____ c) _____	10. (a) Is the device being ordered as an adjunct to repeat single level spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s)? (b) How many months prior to ordering the device did the patient have the repeat fusion? (c) How many months prior to ordering the device did the patient have the previously failed fusion?
Y N D	11. Is the device being ordered following multi-level spinal fusion surgery?
Y N D	12. Has there been at least one open surgical intervention for treatment of the fracture?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description of Equipment and Cost**

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating 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.