Ohio Department of Job and Family Services

CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
IPPV OR APAP IN LIEU OF A VOLUME VENTILATOR

Certification Type: ☐ Initial ☐ Revised ☐ Recertification

Instructions: The Certificate of Medical Necessity (CMN) must be used for approved ventilators under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of consumer	Medicaid billing#

Street address	City/State/Zip	Date of birth

List other respiratory equipment in use

Section A—Must be completed by prescriber

Diagnosis(es) Include ICD-9 code and description

Date of last examination by prescriber (must be within 30 days prior to first date of service)	Consumer has permanent tracheostomy ☐ Yes ☐ No

Medical history (attach hospital discharge summary, if applicable)

☐ APAP or ☐ IPPV device is required for ventilatory support/only effective alternative to a volume ventilator	Length of need ☐ Short term, # of months ☐ Chronic/permanent

Ventilatory support requirements	Ventilator settings/parameters
☐ Continuous ☐ Nocturnal only ☐ Other, explain:	O2 setting

Prescriber's name (PRINTED)

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature	Date	Ohio Medicaid Legacy # NPI #

Section B—Must be completed by Licensed Respiratory Care Professional (LRCP)

Complete this section if the ventilator was dispensed prior to submitting prior authorization request

Licensed respiratory care professional services	Home visits first week ☐ 5-7 ☐ 3-4 ☐ 1-2
Date placed on ventilator ☐ Yes ☐ No Home evaluation prior to hospital discharge? ☐ Yes ☐ No Home set up? ☐ Yes ☐ No In-home training provided to care givers? If "yes", check all that apply: ☐ Ventilator operation ☐ Tracheostomy care ☐ Cleaning/sterilizing technique	Home visits after the first week (at least monthly) Dates: 1) 2) 3) 4) 5) 6) Is the consumer being weaned? ☐ Yes ☐ No

LRCP name *(PRINTED)*

I certify that I am the respiratory therapist identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

LRCP signature	Date	License #