# Medicaid

## Montana Medicaid Certificate of Medical Necessity

Durable Medical Equipment (DME) and Supplies (Rev. October 2014)

## Parenteral Therapy

| **Patient Name, Address, Telephone Number, and Date of Birth**<br><br>**Medicaid ID Number**_____ | **Physician Name, Address, and Telephone Number**<br><br>**NPI Number** _____ | |
|---|---|---|
| **Diagnosis** | **Height** | **Weight** |
| **Prognosis** | **Estimated Length of Need (Months) 1–99 (99=Lifetime)** | |

1. Description of functional impairment?
   - ☐ Malabsorption
   - ☐ Swallowing impairment
   - ☐ Hyper metabolic
   - ☐ Impaired consciousness
   - ☐ Nonfunctioning GI tract
   - ☐ Intestinal obstruction
   - ☐ Aspiration
   - ☐ Other _____
   - ☐ Mental incapacity
   - ☐ Nausea/Vomiting

2. Formula components?
   - ☐ Amino Acid _____ (ml/day) _____ concentration % _____ gms protein/day
   - ☐ Dextrose _____ (ml/day) _____ concentration %
   - ☐ Lipids _____ (ml/day) _____ days/week _____ concentration %

3. Residence ☐ Home ☐ Nursing Home ☐ Hospital Rehab Unit ☐ Institution ☐ Group Home ☐ Other_____

4. Does the patient have severe, disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? ☐ Yes ☐ No

5. How many days per week is the patient infused? (1–7) _____

6. Route of administration ☐ Central Line ☐ Hemodialysis Access Line ☐ Peripherally Inserted Catheter (PIC)

7. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients? ☐ Yes ☐ No

8. Narrative description of **all** items, accessories, options, and special additives ordered to include supply changes and amounts. If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document).
   - ☐ **Yes**, additional attachments **are** included.
   - ☐ **No**, additional attachments **are not** included.

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

**Signature and date stamps are not acceptable.**

_____ **Physician's Signature**

_____ **Date (mm/dd/yyyy)**