Oklahoma HealthCare Authority

CERTIFICATE OF MEDICAL NECESSITY
EXTERNAL INFUSION PUMP

SECTION A **Certification Type/Date: INITIAL**____/____/____ **REVISED**____/____/____ **RECERTIFICATION**____/____/____		
PATIENT NAME, ADDRESS, TELEPHONE and MEMBER NUMBER (__ __ __) __ __ __-__ __ __ __ MEMBER # _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC OR applicable NPI NUMBER/LEGACY NUMBER (__ __ __) __ __ __-__ __ __ __ NSC OR NPI # _____
PLACE OF SERVICE _____	HCPCS CODE	PT DOB ____/____/____ Sex _____ (M/F) Ht. ____(in) Wt. _____(lbs.)
NAME and ADDRESS of FACILITY *If applicable*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and applicable NPI/LEGACY NUMBER (__ __ __) __ __ __-__ __ __ __ NSC 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	ANSWER QUESTIONS 1-7 FOR EXTERNAL INFUSION PUMP. (Circle **Y** for Yes, **N** for No or D for Does Not Apply, Unless Otherwise Noted).
1 3 4 ☐☐☐	1. Circle number of pump which has been prescribed 1—External infusion pump (non disposable) 2---Reserved for other or future use 3---Implantable infusion pump 4---Disposable infusion pump (e.g. elastometric)
HCPCS CODE _____	2. Provide the HCPCS code for the drug that requires the use of the pump.
_____	3. If non-specific code was used to answer question print the name of the drug.
1 3 4 ☐☐☐	4. Circle number for route administration. 1---Intravenous 2---Reserved for other or future use 3---Epidural 4---Subcutaneous
1 2 3 ☐☐☐	5. Circle number for method of administration. 1---Continuous 2---Intermittent 3---Bolus
_____	6. What is the total duration of drug infusion per 24 hours? (1-24).
Y N D ☐☐☐	7. Does the patient have intractable cancer pain, which has failed to respond to an adequate oral/transdermal narcotic analgesic regime, or is the patient unable to tolerate oral/transdermal narcotics?

To expedite timely review, medical records to support the above statement must be submitted at the time of request.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PYSICIAN (Please print):

NAME: _____ TITLE:_____ EMPLOYER:_____

SECTION C Narrative Description of Equipment and Cost.

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

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 _____/_____/_____