MEDICAID FORM

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR INTERMITTENT ASSIST DEVICE (BIPAP)

Certification Type/Date: INITIAL ____/____/____ REVISED ____/____/____

Members Name:	Members Medicaid Number (Do Not List Mother's ID):
Patient DOB ____/____/____ Sex ____ HT. ____ (in) WT. ____ (lbs.)	
Suppliers Name: Professional Medical HHC Suppliers NPI Number: 1942287131	Suppliers Address and Telephone Number: 4855 Memorial Drive Stone Mountain, GA 30083 404-292-9190
Physicians Name: Physicians NPI Number:	Physicians Address and Telephone Number:

HCPCS Code(s)	
Place of Service	

Primary Diagnosis____________________ ICD-10 Diagnosis Code____________

Secondary Diagnoses supporting medical necessity:____________________

ICD 10 Diagnosis Code(s)____________ Length of Need ____________

Has the member had a trial with a CPAP device? ☐ Yes ☐ No

If yes, describe the results of the trial:

____

____

Describe the member's current condition:

____

____

Will the intermittent assist device provide an alternative to a tracheotomy? ☐ Yes ☐ No

Complete all the following if BIPAP ST is ordered:

BIPAP Level ________ IPAP ________ EPAP ________ Respiratory Rate ________

Complete all the following if BIPAP S is ordered: IPAP ________ EPAP ________

I certify that the intermittent assist (BIPAP) device requested is medically necessary for this member, and that I have had a face-to-face evaluation with this member within the six (6) months preceding this order, and I am enrolled with Georgia Medicaid for the purpose of ordering, referring, or prescribing medical services.

Date of face-to-face evaluation ____/____/____ (Must have occurred within 180 days prior to the order date)

Physician's Signature ______________________________ Date____/____/____

Additionally, the respiratory therapist or certified sleep technologist responsible for instruction and fitting of the mask must sign and date below, and the license or certification number must be listed.

Signature of RT/CST ______________________________ Date ____/____/____

Certification or License # ______________________________ Expiration Date ____/____/____

Stamps are not an acceptable form of authentication for the date or signature on a certificate of medical necessity or prescription/written order submitted to Georgia Medicaid.

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