MEDICAID FORM

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR GROUP I PRESSURE REDUCING SUPPORT SURFACE

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 _____

Risk Factors for decubitus ulcers include:

☐ Altered mobility ☐ Bedbound ☐ Poor nutritional status

☐ Incontinence of Bladder or Bowel ☐ Increased pressure over bony prominences ☐ Edema

Does the member presently have decubitus ulcers or skin irritation?

☐ Yes ☐ No

Stage of decubitus, if present:

☐ I ☐ II ☐ III ☐ IV

I certify that the pressure reducing support surface 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 ____/____/____

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.