MEDICAID FORM

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CERTIFICATION OF MEDICAL NECESSITY FOR RESPIRATORY SUCTION PUMP

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)	E0600
Place of Service	HOME (12)

Primary Diagnosis _____ICD-10 Diagnosis Code_____

Secondary Diagnoses supporting medical necessity: _____

ICD-10 Diagnosis Code(s) _____

Estimated length of need? _____Months

The member has difficulty clearing secretions that requires the use of a suction pump due to secondary (select all that apply):

☐ Cancer of the throat or mouth
☐ Dysfunction of the swallowing muscles
☐ Unconsciousness or obtunded state
☐ Tracheostomy

This situation below will be reviewed on a case by case basis and the ordering physician should provide any available documentation that the supports the medical necessity.

☐ Copious oral secretions without the ability to clear mucous (Explain)

_____

_____

_____

I certify that the respiratory suction pump 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.