MISSISSIPPI DIVISION OF MEDICAID
MEDICAL SUPPLY CERTIFICATE OF MEDICAL NECESSITY & PLAN OF CARE

This form is required for all medical supplies billed to Mississippi Medicaid (except diapers and underpads – see Section 10.32). This form must be completed and signed by the ordering physician, nurse practitioner, or physician assistant every 12 months. Medical supplies provided without a current signed prescription and/or Medical Supply CMN/POC form are not covered.

Beneficiary Name:	Beneficiary Medicaid ID #:
DME Provider Name:	DME Provider Medicaid #:
Prescribing Provider Name:	Prescribing Provider Medicaid # or MS License #:
	Prescribing Provider Phone#:
Beneficiary Diagnosis/ICD-9 Diagnosis Codes: *Diagnoses must relate to and justify the need for the prescribed medical supplies.*	

Prescribed Medical Supplies

Description	HCPCS Codes	Provider Charge, MSRP, or Invoice Cost	Deliver Date	Dates of Need From	Dates of Need Thru	Quantity (#) Delivered

DME PROVIDER ATTESTATION, SIGNATURE, AND DATE:

I certify that those items listed on this form are those exact items ordered and certified as medically necessary by the ordering physician/nurse practitioner/physician assistant whose signature appears on this form, and that these exact items will be delivered to the beneficiary listed on this form. A DME provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medical benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medical services.

SIGNATURE OF DME PROVIDER _____ DATE _____

PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT ATTESTATION, SIGNATURE, AND DATE:

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed medical supplies listed on this form, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified on this form. I certify that medical necessity information listed on this form is true, accurate, and complete to the best of my knowledge. I certify that I have reviewed the items listed on this form and that I deem them medically necessary for the patient listed on this from. I understand that any falsification, omission or concealment of material fact may be subject to civil monetary penalties, fines, or criminal prosecution.

SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT _____ DATE _____