



Appendix B – Medicaid Certificate of Medical Necessity

DELAWARE HEALTH
AND SOCIAL SERVICES

General Instructions

<ul style="list-style-type: none"> Incomplete or illegible forms will be returned and may delay the authorization process. Review the Delaware Medical Assistance Program manuals for instructions and form downloads at http://www.dmap.state.de.us/downloads/manuals.html 	<ul style="list-style-type: none"> Date Received: _____ Date Eligible: _____ Supporting Documentation <input type="checkbox"/> YES <input type="checkbox"/> NO TPL: <input type="checkbox"/> YES-Type: _____ <input type="checkbox"/> NO
FAX completed forms to: 302-255-4481 Telephone: 302-255-9500	DMMA Prior Authorization/Lewis Bldg 1901 N. DuPont Hwy.P.O. Box 906 New Castle, DE 19720
Comments:	

A. PROVIDER INFORMATION

Name: Prentke Romich Company	FAX Number: 330-202-5840
Address: 1022 Heyl Rd., Wooster, OH 44691	
Contact Name:	Telephone Number: 800-262-1984
NPI (Provider ID#): 1184602518	Taxonomy: 332BC3200X

B. CLIENT / PATIENT INFORMATION

Name:	Medicaid ID#:
Service Dates: FROM: _____ TO: _____	Continuation of Service <input type="checkbox"/> Yes <input type="checkbox"/> No
DOB: _____	Diagnosis(es): _____

C. EQUIPMENT / SUPPLY(IES) (List additional items on "Continuation Form.")

HCPCS CODE	MOD	DESCRIPTION	TOTAL # OF UNITS	TOTAL U&C CHARGE

MOD(Modifier): Use "NU" for Purchase New, "UE" for Purchase Used, or "RR" for Rental;
Include Brand Name and Serial/Product Number as part of the description

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)**

D. PRACTITIONER AUTHORIZATION IMPORTANT: This section must be completed by the attending physician/practitioner.

Name (print):	Telephone Number:
Address:	
Contact Name:	FAX Number:
NPI (Provider ID#):	
Signature:	Date:

I certify that the services described above are medically necessary for the identified patient/client.

DO NOT WRITE BELOW THIS LINE

Date Reviewed:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Incomplete	Authorization #:
Signature:	Comments:	

