Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: VENTILATORS

Identifying Information [This section may be completed by the provider.]

Individual	**Prescriber**	**Provider**
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of evaluation

Conditions for which ventilatory support is needed

☐ Chronic respiratory failure ☐ Spinal cord injury ☐ Neuromuscular disease ☐ A chronic pulmonary disorder

☐ Another neurological disorder or thoracic restrictive disease _____

☐ This individual has undergone a permanent tracheostomy.

Estimated length of need ○ _____ months ○ Indefinite/perpetual ☐	Continuity of support required ☐ Constant ☐ During the day ☐ At night ☐ For sleep only ☐ Other _____

Description of ventilator

Type _____ Mode _____

Settings or parameters _____

☐ Attached is documentation showing that this individual is being weaned.

Other respiratory equipment in use

☐ A secondary or back-up ventilator is necessary.

- ☐ The individual cannot maintain spontaneous respiration for at least four hours.
- ☐ Because of regular activities outside the home (e.g., school, outpatient therapy), the individual needs a second ventilator with a suitable power source.
- ☐ The average emergency medical team response time to the individual's address is estimated to be more than two hours.

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.