Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: COMPRESSION GARMENTS

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
Address*	Telephone number	

*Note: Provision of or payment for equipment and supplies used by a resident of a long-term care facility (LTCF) is the responsibility of the LTCF.

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

Mark all items that apply.

Diagnosis code(s)	Date of evaluation

- ☐ Elephantiasis
- ☐ Lymphedema
- ☐ Milroy's disease
- ☐ Orthostatic hypotension
- ☐ Post-thrombotic syndrome
- ☐ Stasis dermatitis
- ☐ Stasis ulcers
- ☐ Symptomatic chronic venous insufficiency
- ☐ Symptomatic venous insufficiency associated with pregnancy
- ☐ Thrombophlebitis
- ☐ Other condition: _____ _____ _____

For each compression garment requested, identify the style and compression by code, and indicate the quantity.
Attach a copy of the manufacturer's price list.

Style: S1 = Knee-length, S2 = Thigh-length, S3 = Chap, S4 = Pantyhose, S5 = Other _____

Compression: C1 = 18–30 mm Hg, C2 = 30–40 mm Hg, C3 = 40–50 mm Hg

Garment 1: Style _____ Compression _____ Quantity _____
Garment 2: Style _____ Compression _____ Quantity _____
Garment 3: Style _____ Compression _____ Quantity _____
Garment 4: Style _____ Compression _____ Quantity _____
Garment 5: Style _____ Compression _____ Quantity _____

Provide the following information.

For anti-embolism compression garments: Date of surgery ___/___/_____ Length of need (in months) _____

For post-burn compression garments: Date of burn injury ___/___/_____

Explain the necessity of any custom item.

Attestation [This section must be signed 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.