Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: INSULIN PUMPS

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
Height (in.) Weight (lbs.)	Telephone number	
Address*	*Note: Provision of or payment for equipment and disposable 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 face-to-face assessment

☐ The individual has type 1 diabetes mellitus.

☐ The individual has the following symptoms or conditions (marked when applicable):

- ☐ Glycated hemoglobin level (HbA1c) greater than 7%
- ☐ A history of recurring hypoglycemia
- ☐ Wide fluctuations in blood glucose before mealtime
- ☐ A marked early-morning increase in fasting blood sugar (the "dawn phenomenon")
- ☐ A history of severe glycemic excursions

☐ The individual has completed a diabetes education program within the preceding twenty-four months.

☐ The individual has been on a maintenance program for at least six months involving at least three injections of insulin per day and frequent self-adjustments of insulin dosage.

☐ The individual has performed glucose self-testing at least four times per day on average during the preceding month.

☐ The individual is at high risk for preventable complications of diabetes.

Certification for Additional Rental or Purchase [This section may be transcribed by the provider.]

Mark all items that apply.

☐ Rental: Requested dates from __/__/____ to __/__/____ ☐ Purchase Prior dates from __/__/____ to __/__/____	Prior PA number

☐ The individual (or someone assisting the individual) is capable of managing the pump and that the desired improvement in metabolic control can be achieved.

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.