Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: HIGH-FREQUENCY CHEST WALL OSCILLATION DEVICES

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 for the Initial Trial Period [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Dates From ___/___/_____ to ___/___/_____
Frequency of treatment sessions	Duration of treatment sessions

☐ This individual has cystic fibrosis that has not been ameliorated by any other treatment.
☐ This individual has bronchiectasis or pneumonia with chronic, excessive, retained bronchopulmonary secretions.
☐ This individual has a medical history of chronic or recurrent respiratory infections or pneumonia that require antibiotics and multiple hospitalizations and are unresolved by other bronchial hygiene therapy.
Most recent hospitalizations: from ___/___/_____ to ___/___/_____, from ___/___/_____ to ___/___/_____
☐ This individual has another respiratory condition: _____.

☐ Other airway-clearance treatments are ineffective or contraindicated.
Treatments attempted _____
Contraindications _____

☐ Other individuals will be sharing equipment (e.g., a generator).
Name _____ Relationship _____ Medicaid ID number _____
Name _____ Relationship _____ Medicaid ID number _____

Certification Beyond the Initial Trial Period [This section may be transcribed by the provider.]

☐ **Rental** – from ___/___/_____ to ___/___/_____	☐ **Purchase**
☐ *The high-frequency chest wall oscillation device proved to be effective during the trial period.*	
Frequency of treatment sessions (if different)	Duration of treatment sessions (if different)
☐ **Rental** – from ___/___/_____ to ___/___/_____	☐ **Purchase**
☐ *The high-frequency chest wall oscillation device proved to be effective during the previous rental period.*	
Frequency of treatment sessions (if different)	Duration of treatment sessions (if different)

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 (initial trial period)	Date of signature
Signature of prescriber (beyond initial trial period)	Date of signature
Signature of prescriber (beyond previous rental period)	Date of signature

False certification constitutes Medicaid fraud.