SD DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
Phone 605.773.3495

DSS
Strong Families - South Dakota's Foundation and Our Future

Certificate of Medical Necessity

RECIPIENT NAME: _____ **Date of Birth**_____

MEDICAID ID NUMBER: _____

DIAGNOSIS - Including an explanation of the particular problem resulting from the diagnosis which relates to this equipment request (if O_2 is being prescribed please include the results of the most recent test, the condition of the test- at rest, during exercise or during sleep):

PROGNOSIS:

EXPLANATION OF THE MEDICAL NECESSITY/JUSTIFICATION FOR CONTINUED RENTAL:

OXYGEN PRESCRIPTIONS ONLY:

☐ **STATIONARY** ☐ **PORTABLE** (if portable the recipient must be mobile within their home)

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre SD 57501, 605-773-3305.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).

HOW LONG IS THIS CONDITION EXPECTED TO LAST?

MONTHS _____ **INDEFINITELY** ☐ **PERMANENTLY** ☐

EQUIPMENT BEING PRESCRIBED; INCLUDING CPT CODE/S:

PHYSICIAN'S SIGNATURE:_____**DATE**: _____

PHYSICIAN'S NPI:_____

EXPLANATION OF THE EQUIPMENT'S FUNCTION:

MANUFACTURER: **EQUIPMENT SERIAL #:**

EQUIPMENT STATUS: ☐ **NEW RENTAL** ☐ **CONTINUOUS RENTAL**

☐ **PURCHASE** ☐ **REPAIR**

PURCHASE PRICE: $

RENTAL PRICE (Per month price)**: $**

DME PROVIDER NAME: **DME PROVIDER'S NPI:**

DME PROVIDER MAILING ADDRESS:

DME CONTACT NUMBER: **DME FAX NUMBER:**

DME PROVIDER'S CONTACT NAME:

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