CERTIFICATE OF MEDICAL NECESSITY

Cabinet for Health & Family Services
Department for Medicaid Services Metabolic Formulas and Foods

Section A

Recipient Name: _____ MAID Number: _____
Recipient Address: _____
Phone Number: _____ Date of Birth: _____

Section B

Provider Name: _____ Provider Number: _____
Provider Address: _____
Phone Number: _____ Fax Number: _____

Section C

Product prescribed: _____

Section D

Prescriber Name: _____Prescriber Address: _____
Prescriber KY Medicaid Number: _____ Phone Number: _____
Fax Number: _____

Areas below must be completed by prescriber and not the supplier of the equipment/supply ordered.

Section E

Date of Request: _____ Initial CMN Request: _____ Date Last Seen by Prescriber: _____

Section F

Primary Diagnosis: (Check applicable) ____Phenylketonuria____Hyperphenylalaninemia___Tyrosinemia (Types I, II, III) ____
Branched-chain Amino-Acid Disturbance, specify: _____
Urea Cycle Disorder, specify: _____
_____Methylmalonic acidemia ____Other, please specify: _____

Section G

Pertinent medical history, diagnostic tests, treatment plan.

How often will the client be seen? _____Date therapy initiated: _____

Section H

I certify that I am the prescriber identified in Section A of this form. I have received Sections A, B, C, and D of the Certificate of Medical Necessity (including charges for items ordered). I certify that I or my medical staff has completed Sections E, F, and G. This CMN and any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section E, F, and G is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's printed Name:

_____Signature:_____

(Signature and date stamps are not acceptable.)

Date _____