Tufts Health RITogether

Durable Medical Equipment + Medical Supplies
General Prescription and
Medical Necessity Review Form

Please fax form to: 857.304.6404

Effective prescription date: _____/_____/_____

Sections 1-5 must be completed by the DME providers. Sections 4A, 4B, 5A, 6, and 7 must be completed by member's prescribing provider

Section 1: Member information

Name: _____
Address: _____
_____
_____
ICD code(s): _____/_____/_____/_____/_____
_____/_____/_____/_____/_____/_____

RI Medicaid #:_____
Tel.#:_____
Date of birth: _____/_____/_____
Gender: _____
Height: _____
Weight: _____

Diagnosis: _____
_____

Section 2: Prescribing provider information

Name: _____
Address: _____
_____
_____

Tel.#:_____
NPI #: _____
Fax #: _____

Section 3: DME provider information

Name: _____
Address: _____
_____
_____

Tel.#:_____
NPI #: _____
Fax #: _____

Section 4: DME equipment only

Items Requested	*HCPCS Code*	*Modifiers*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Section 4A: (Must be completed by prescribing provider or the prescribing provider's employee).

Length of Need (in months)

1. _____
2. _____
3. _____
4. _____
5. _____

(See **Section 4B** on following page for additional listings)

Section 5: For medical supplies only

Items Requested	*HCPCS Code*	*Modifiers*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Section 5A: (Must be completed by prescribing provider or the prescribing provider's employee)

Monthly quantity	*# of refills*
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Section 6

Medical justification for requested item(s) along with any settings, therapeutic outcomes, and previous treatment plans (if applicable). Please attach any pertinent documentation (i.e., lab tests, etc.)

_____
_____
_____
_____

Section 7- Prescribing provider's attestation, signature, and date

I certify that I am the prescribing provider identified in Section 2 of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information per (130 CMR 450.204) on this form is true, accurate, and complete to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

_____

Prescribing provider's signature (Signature and date stamps are not acceptable) Date

Section 4B: For additional listings, if needed

Items Requested	*HCPCS Code*	*Modifiers*	*Quantity*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____		_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

9. _____ _____ _____ _____
10. _____ _____ _____ _____
11. _____ _____ _____ _____
12. _____ _____ _____ _____
13. _____ _____ _____ _____
14. _____ _____ _____ _____
15. _____ _____ _____ _____
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17. _____ _____ _____ _____
18. _____ _____ _____ _____
19. _____ _____ _____ _____
20. _____ _____ _____ _____
21. _____ _____ _____ _____
22. _____ _____ _____ _____
23. _____ _____ _____ _____
24. _____ _____ _____ _____
25. _____ _____ _____ _____
26. _____ _____ _____ _____

Section 8- Provider of DME attestation, signature, and date

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and it is true, accurate, and complete to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material contained herein. Note: Signature and date stamps, or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of legal entity is not acceptable.

_____

Provider of DME signature Date

_____ _____

Printed legal name of provider Printed legal name of individual signing