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MassHealth

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

Effective Date of Prescription: _____

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

Section 1 – Member's Information

Member's name: _____ MassHealth ID no.: _____

Address: _____ Tel. no.: _____

_____

Date of birth: _____ Gender: _____ Height: _____ Weight: _____

ICD-9-CM code: _____/_____/_____/_____/_____/_____

Diagnosis: _____

Section 2 – Prescribing Provider's Information

Prescribing provider's name: _____ Tel. no.: _____

Address: _____ NPI: _____

_____ Fax no.: _____

Section 3 – DME Provider Information

DME provider name: _____ Tel. no.: _____

Address: _____ NPI: _____

_____ Fax no.: _____

Section 4 – For Durable Medical 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:
1.
2.
3.
4.
5.
6.

Section 5 – For Medical Supplies Only

Items Requested:	HCPCS Code:	Modifiers:
1.		
2.		
3.		
4.		

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

Quantity Monthly:	Number 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 information (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 not acceptable) Date

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Instructions for Completing the Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form

(Sections 1, 2, 3, 4, and 5 must be completed by DME provider.)

Instructions for the Use of this Form	DME providers should use this form when obtaining a prescription and letter of medical necessity from the member's prescribing provider for DME, and as an attachment to a prior authorization request. This form will not be accepted in certain circumstances, such as when a MassHealth Medical Necessity Review Form exists for specific DME (such as absorbent products, enteral products, and support surfaces products). The DME provider is responsible for ensuring compliance with applicable MassHealth regulations and requirements when completing this form. MassHealth reserves the right not to accept the form if it is completed improperly, or if the DME provider has failed to meet applicable MassHealth regulations, requirements, and guidelines.
Effective Date of Prescription	Enter the date of service.
Section 1	Enter the member's name, MassHealth member ID number, home address (including apartment number if applicable), telephone number, date of birth, gender, height, weight, ICD-9-CM code(s), and diagnosis that pertain to the items being dispensed.
Section 2	Enter the prescribing provider's name, telephone number, address, NPI, and fax number.
Section 3	Enter the DME provider's name, telephone number, address, NPI, and fax number.
Section 4	This section is for durable medical equipment only. Enter the description of the item(s) being supplied, the HCPCS code, and the appropriate modifier(s) being used for billing, as applicable.
Section 5	This section is for medical supplies only. Enter the description of the item(s) being supplied, the HCPCS code, and the appropriate modifier(s) being used for billing, as applicable.
(Sections 4A, 5A, 6, and 7 must be completed by prescribing provider.)	
Section 4A	Enter the length of need (in months).
Section 5A	Enter the monthly quantity and the number of refills (in months).
Section 6	Enter the medical justification for all items listed above. Include (if applicable) settings, therapeutic outcomes, and previous treatment plans. Attach any applicable supporting medical documentation (i.e., lab tests, etc.).
Section 7	The prescribing physician, nurse practitioner, or physician assistant, as appropriate, must sign and date the form. By signing the form, the prescribing provider is making the certifications contained above the signature line.
If you have any questions about how to complete this form, please call MassHealth Customer Service at 1-800-841-2900.	