GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

BUREAU OF HEALTH CARE FINANCING ADMINISTRATION

CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES

A Prior Authorization request for DME and/or supplies. The following information will be required for a coverage review. Failure to provide all of the following information will result in a denial of the request.

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_____ Date of Birth: _____/_____/_____

Patient's Name

Telephone Number: _____ Health Insurance ID#: _____

_____ _____

Mailing Address Physical/Home Address

_____ _____

City, State, Zip Code City, State, Zip Code

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Description of medical supplies and/or equipment being requested:

_____ _____

_____ _____

_____ _____

(Provide a <u>DETAILED PRESCRIPTION</u> for DME provider indicating <u>usage, quantity and/or # of refills of requested supplies and/or equipment</u> that <u>patient does not have</u>.)

Diagnosis- INCLUDING AN EXPLANATION OF THE PARTICULAR PROBLEM RESULTING FROM THE DIAGNOSIS WHICH RELATES TO THIS EQUIPMENT AND SUPPLY REQUEST (an example of this requirement would be a diagnosis of cerebral palsy - problem being unable to ambulate and wheelchair bound):

_____

_____

_____

Date of Onset: _____ Prognosis: _____

How long is this problem expected to last? ☐ Indefinitely ☐ Permanently

Physician's description of the patient's current functional status and need for the requested equipment:

_____

_____

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PATIENT'S PHYSICAL/MENTAL STATUS

Walks Independently:	☐ Yes ☐ No	Alert:	☐ Yes ☐ No
Walks w/assistance:	☐ Yes ☐ No	Confused:	☐ Yes ☐ No
Wheelchair bound:	☐ Yes ☐ No	Lethargic:	☐ Yes ☐ No
Bedridden:	☐ Yes ☐ No	Comatose:	☐ Yes ☐ No

Deaf:	☐ Yes ☐ No	Incontinent	
Blind:	☐ Yes ☐ No	Bladder:	☐ Yes ☐ No
Aphasic:	☐ Yes ☐ No	Bowel:	☐ Yes ☐ No

Other (specify): _____

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PHYSICIAN attestation and signature/date:

I certify that this patient is under my care. I certify that the medical necessity information is true and accurate, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician's Name: _____ Telephone Number: _____

Physician's Signature: _____ Date: _____