# DEPARTMENT OF VERMONT HEALTH ACCESS (DVHA)

# VERMONT MEDICAID MEDICAL NECESSITY FORM (MNF) FOR MEDICAL SUPPLIES AND EQUIPMENT

**Referring provider:** All supplies and equipment require a written order. Orders must be signed by a practitioner operating per Vermont Health Care Administrative Rules 4.208.3 and 4.209.3. All home health plans of care require a physician signature. It is the responsibility of the referring provider to complete or review this MNF and provide adequate documentation supporting the medical need for the items requested. The referring provider must provide this documentation either for the Medicaid member to take to the supplying provider of choice, or directly to the supplying provider.

**Supplying provider:** The supplying provider must be enrolled in Vermont Medicaid. The supplying provider must document a description of the device and/or its HCPCs code. If the referring provider does not provide the HCPCs code, the supplying provider must provide the HCPCs code for all prior authorizations, on all claims, on this form, or on other documentation submitted to the DVHA and Gainwell Technologies. The codes submitted to DVHA and Gainwell Technologies must match the description documented by the referring provider.

**Copies** of the order must be kept in the member’s record by both the referring and the supplying provider. All requests must adhere to state and federal rules and regulations. Vermont Medicaid Rules can be found online at <http://humanservices.vermont.gov/on-line-rules>.

**Prior Authorization:** The DME supplier must include a copy of an MNF, or a standard or detailed written order, with every Prior Authorization request. The prescription and current documentation must be updated every 12 months and submitted with all requests. Fax the MNF and any other supporting documents to the DVHA **at** **(802) 879-5963.** Use of the DVHA Medical Necessity Form is recommended for all prior authorization requests to ensure timely processing.

Medicaid may request a copy of the medical record upon audit.

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|  **Section A:** (must be completed or reviewed and signed by referring provider)1. **Member Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medicaid ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Diagnoses**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**3. Place of Service:** Is the member living in a skilled nursing facility? Yes [ ]  No[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| --- | --- | --- | --- | --- | --- |
| **4. HCPCs Code** | **Description** | **Modifier** | **Medical Necessity of Item** | **Expected Length of Need (months)** | **# Per Month** |
| \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ |
| \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_ |
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I CERTIFY THAT THE ITEM(S) PRESCRIBED ABOVE IS (ARE) A MEDICALLY NECESSARY PART OF THE COURSE OF TREATMENT AND NOT FOR CONVENIENCE, COMFORT, OR PRECAUTIONARY PURPOSES

**5. Referring provider’s name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B:** (Must be completed by the supplying provider)

**7. Name of supplying provider employee completing above information**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medicaid provider #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*See back of form for DME information and instructions

**\*INSTRUCTIONS FOR SECTIONS A & B\***

**Section A** must be completed or reviewed, signed, and dated by the referring provider.

1. Member’s first & last name, Medicaid ID number, and date of birth.
2. List all relevant diagnoses, including status diagnoses such as colostomy, tracheostomy. If this is an initial request or there have been significant clinical changes, attach documentation reflecting the provider’s treatment plan.
3. Specify if the item is to be used in a skilled nursing facility.
4. List for each item being ordered: HCPCS code (optional for referring provider, but then must appear on other documentation submitted to DVHA for PA and to Gainwell Technologies for claims), medical necessity rationale, expected length of need (will be interpreted as months unless stated otherwise), and the number of items needed (for example: 2 bottles of sterile saline per month x 12 months). NOTE: If the quantity requested is more than the number allowed (based on customary usage and as listed in the DVHA Durable Medical Equipment (DME) Restriction list, available at: <https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment>), an explanation from the referring provider is required.
5. The referring provider’s name, Medicaid provider number, and phone number.
6. The referring provider’s signature must be that of the referring provider and attests to the validity of the information given. The date of this signature is also required.

**Section B** must be completed by the supplying provider when equipment and/or supplies are ordered.

1. The name of the supplying provider employee completing the form, the phone number, and Medicaid provider number of the supplying provider.