Save

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 07.02B

POWER OPERATED VEHICLE (POV)

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE _____ _____ _____ _____	**PT DOB** ___/___/___; **Sex** ___ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)** **PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __- __ __ __ __**

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 6 - 14 FOR POWER OPERATED VEHICLE (POV) (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
	Questions 1 - 5, and 9 - 11, reserved for other or future use.
Y N D	6. Does the patient require a POV to move around in their residence?
Y N D	7. Have all types of manual wheelchairs (including lightweights) been considered and ruled out?
Y N D	8. Does the patient require a POV only for movement outside their residence?
Y N D	12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	13. Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	14. Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

Qt	Manufact	Model	Part Number	Description	Code	Modifier	Billed	Allowable

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B 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 SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM HCFA 850 (4/96)