VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES

SECTION I INDIVIDUAL DATA — SERVICING PROVIDER

INDIVIDUAL DATA		SERVICING PROVIDER	
I.D. #		I.D. #	1790999621
Name		Name	Tidewater Lactation Group, Inc.
D.O.B.		Contact Person	Elizabeth I Flight, BSN, RN, IBCLC
Phone #		Phone #	757-422-5502

Note: The CMN can now be used to meet the Face-to-Face requirements for applicable codes.

SECTION I INDIVIDUAL INFORMATION

Answer all questions that are applicable to DME service being requested.
If answer is yes, you must describe/attach additional information.

Does patient:	YES	NO
1. have impaired mobility?	☐	☐
2. have impaired endurance?	☐	☐
3. have restricted activity?	☐	☐
4. have skin breakdown? (Describe site, size, depth and drainage)	☐	☐
5. have impaired respiration? (Identify most recent PO_2 ________/Saturation level ________ for patients on oxygen)	☐	☐
6. require assistance with ADL's?	☐	☐
7. have impaired speech?	☐	☐
*** 8. a) require nutritional supplements? (If yes, answer b and c below.) b) sole source or primary source (circle one) c) height __________ weight ______________	☐	☐

DESCRIPTION/ADDITIONAL INFORMATION:
(Additional space on reverse)

Patient has indicated a desire to breastfeed and pump for her infant due or born on __/__/__

FACE-TO-FACE COMPLETED YES☐ NO☐ N/A ☐

____

NAME/TITLE/ AND DATE OF PRACTITIONER WHO COMPLETED FACE-TO-FACE

IS THE ITEM SUITABLE FOR USE IN THE HOME AND DOES THE INDIVIDUAL/CAREGIVER DEMONSTRATE WILLINGNESS/ABILITY TO USE THE DME? YES☐NO☐

Date last examined by practitioner ______________

ICD Code	Clinical Diagnoses	Date of Onset: Less than 6 months	Date of Onset: Greater than 6 months
Z391	Encounter for care and examination of a lactating mother	☑	☐
		☐	☐
		☐	☐
		☐	☐

SECTION III (ADDITIONAL SPACE ON REVERSE)

Begin Service Date	HCPCS Code	Item Ordered Description*	Length of Time Needed	Quantity Ordered/ x1 Month*	Frequency of Use*/ Justification/Comments/ Calories Per Day
	E0602	Manual Breast Pump	12 Mos	1	As needed
	E0603	Double Electric Breast Pump	12 Mos	1	As needed

SECTION IV PRACTITIONER CERTIFICATION (MUST BE SIGNED AND DATED BY THE PRACTITIONER)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PRACTITIONER NAME (print)	PRACTITIONER'S SIGNATURE*	DATE*	I.D.#	PHONE #

*Required fields. If any of these fields are blank the CMN is not valid. The other sections of the CMN can be documented on the CMN or in supporting documentation.
Practitioner's signature does not guarantee payment unless all documentation requirements are met.
Issuance of a PA does not guarantee payment. Payment is contingent upon all appropriate documentation being readily available for review.
Practioners who may complete the Face-to-Face are defined in 12VAC30-50-165 ***Complete diet order must be indicated in Section III