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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, 4B, 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 (dd/mm/yy) Gender Height Weight
ICD code(s) / / / / /
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 Acelleron Medical Products . Tel. no. 978-738-9800, X3
Address 16 High Street, Suite 201, North Andover, MA 01845 . NPI 1184960874
. Fax no. 866-221-0676

Section 4 – For Durable Medical Equipment Only

Items Requested	HCPCS Code	Modifiers
1. Nebulizer Compressor	E0570	NU
2. Nebulizer Cup & Tubing	A7005	NU
3. Nebulizer Mask	A7015	NU
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.

(See page 2 Section 4B, for additional listings.)

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 documentation (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 are not acceptable) Date

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