Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form

All fields with a blue box must be completed to fulfill the breast pump order.

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 ____________________ Tel. no. ____________________
Address ____________________ NPI ____________________
____________________ Fax no. ____________________

Section 4 – For Durable Medical Equipment Only

Items Requested	HCPCS Code	Modifiers
1.		
2.		
3.		
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.).

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____
____

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.

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Prescribing provider's signature (Signature and date stamps are not acceptable) Date

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