Iowa Medicaid Enterprise

Certificate of Medical Necessity for Waiver Assistive Devices

Use this form as your cover page. Fax to Medical Services Waiver Prior Authorization 515-725-1388.

(Please print or type clearly – accuracy is important)

Section A

1. Member Name (Last) (First) (Initial)		2. Case Manager Name
3. Medicaid SID #	4. Date of Birth	5. Service Plan Dates Covered by Request From: Month / Day / Year To: Month / Day / Year
6. Name of Item Requested:		
7. Type of Review Being Requested: ☐ Initial ☐ Continued Stay Review (CSR) ☐ Revised form ☐ Re-review		*Remember to attach all documentation.* 8. Documentation attached? ☐ Yes ☐ No **(see Section D)** 9. Number of pages including this one:

Section B Answer ALL Questions 1 through 6 for Environmental Modification

☐ Yes ☐ No	1. Have other funding sources been tried? Outline in Section C. ☐ Community services fund ☐ Family ☐ Other ☐ Charitable organizations ☐ State plan durable medical equipment
☐ Yes ☐ No	2. Is this device covered by other funding sources? Outline in Section C.
☐ Yes ☐ No	3. Will the device increase or maintain independence of the member? Outline in Section C.
☐ Yes ☐ No	4. Does the device address a health, safety, or welfare issue for this member? Outline in Section C.
☐ Yes ☐ No	5. Does the service plan identify the need for the requested device?
☐ Yes ☐ No	6. Does this device address an ADL or IADL need? Outline in Section C.

Section C Narrative Description Justifying Request

Provide specific information and use additional sheet if necessary. Provide the cost of items that are $50 or under.

IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	Requesting Case Manager Signature of TCM/CM/SW Date

Section D Include ALL of the Following Documentation

- Comprehensive functional assessment
- Case manager or social worker service plan
- Three independent itemized estimates (if over $50)
- Documented description of the item that includes the direct medical, remedial, or safety benefit to the member
- Denial from state plan durable medical equipment, if applicable