Iowa Medicaid Enterprise

Certificate of Medical Necessity for Environmental Modification

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			To		
		Month	Day	Year	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 13 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. Is this an existing structure? If yes, provide detailed information in Section C.
☐ Yes ☐ No	4. If this is an existing structure, can it be repaired? Describe in Section C.
☐ Yes ☐ No	5. Is this modification for the sole benefit of the member? Describe benefit to member in Section C.
☐ Yes ☐ No	6. Are any of the contractors related to the member? If yes, provide relationship in Section C.
☐ Yes ☐ No	7. Will this modification increase or maintain the independence of the member? If yes, outline in Section C.
☐ Yes ☐ No	8. Does this modification address a health, safety, or welfare issue for this member? Outline in Section C.
☐ Yes ☐ No	9. Does the service plan identify the need for requested modification?
☐ Yes ☐ No	10. Will the case manager obtain assurance of liability and workers compensation coverage from contractor?
☐ Yes ☐ No	11. To the best of my knowledge, the contractors submitted for review are reputable?
☐ Yes ☐ No	12. Is there documentation that a mental health professional has recommended this modification? Outline details in Section C.
	13. Does the member or member's family ☐ Own ☐ Live in provider-owned home ☐ Rent ☐ Live in HUD housing

Section C Narrative Description Justification 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)
- Mental health professional recommendation
- Denial for state plan durable medical equipment, if applicable
- If existing item, need repair versus replacement cost estimate
- Documented description of the item that includes the medical, remedial, or safety benefit to the member