MASSHEALTH GENERAL PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR **DURABLE MEDICAL EQUIPMENT** and **MEDICAL SUPPLIES**

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

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 Name			Date of Delivery	
Address			Telephone	
MassHealth ID	Date of Birth	Gender	Height	Weight
Primary ICD Code	Description			
Secondary ICD Code	Description			

SECTION 2

Prescribing Provider's Name	NPI
Address	
Telephone	Fax

SECTION 3

Name of Provider of DME	NPI
Address	
Telephone	Fax

SECTION 4 For Durable Medical Equipment Only

Section 4A (Must be completed by prescribing provider or the prescribing provider's employee.) Use Section 4B for additional listings.

Items Requested	HCPCS Code	Modifiers	Length of Need
1.			1.
2.			2.
3.			3.
4.			4.
5.			5.
6.			6.

SECTION 5 For Medical Supplies Only

Section 5A (Must be completed by prescribing provider or the prescribing provider's employee.)

Items Requested	HCPCS Code	Modifiers	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 (e.g., lab tests, etc.).

Reset form

Member Name

SECTION 7

Prescribing Provider's Attestation, Signature, and Date

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. 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.
For more information refer to Durable Medical Equipment Bulletin 31 and instructions for Section 7.

....
Prescribing provider's signature Date

(Wet & electronic signatures are acceptable. Signature and date stamps, or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

....
For wet signature, print legal name of provider Date

Section 4B For additional listings, if needed

ITEMS REQUESTED	HCPCS	Modifier
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		

Member Name _____

SECTION 8

Provider of DME Attestation, Signature, and Date

I certify under the pains and penalties of perjury 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.

Refer to Durable Medical Equipment Bulletin 31 and instructions for Section 8.

....
Prescribing provider's signature Date

(Wet & electronic signatures are acceptable. Signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable.)

Check applicable credentials: ☐ MD ☐ NP ☐ PA ☐ CNS

....
For wet signature, print legal name of provider Date

Instructions for Completing the Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form

Sections 1 – 5 must be completed by the provider of DME.
Sections 4A, 4B, 5A, 6, and 7 must be completed by the member's prescribing provider.

Instructions for using this Form	DME providers should use this form when obtaining a prescription and letter of medical necessity from the member's prescribing provider for DME, and as an attachment to a prior authorization request. This form will not be accepted in certain circumstances, such as when a MassHealth Medical Necessity Review Form exists for specific DME. The DME provider is responsible for ensuring compliance with applicable MassHealth regulations and requirements when completing this form. MassHealth reserves the right not to accept the form if it is completed improperly, or if the DME provider has failed to meet applicable MassHealth regulations, requirements, and guidelines.
Date of Delivery	Enter the date of service. The date of delivery in Section 1 at the top of page one of this form must match the date of initial delivery on the delivery slip, in accordance with 130 CMR 409.419.
Section 1	Enter the member's name, MassHealth member ID number, home address (including apartment number if applicable), telephone number, date of birth, gender, height, weight, ICD code(s), and diagnosis that pertain to the items being dispensed.
Section 2	Enter the prescribing provider's name, telephone number, address, NPI, and fax number.
Section 3	Enter the DME provider's name, telephone number, address, NPI, and fax number.
Section 4	This section is for DME only. Enter the description of the item(s) being supplied, the HCPCS code, and the appropriate modifier(s) being used for billing, as applicable. Providers of DME that need additional space in Section 4 may use Section 4B (page 2), which is a continuation of Section 4.
Section 5	This section is for medical supplies only. Enter the description of the item(s) being supplied, the HCPCS code, and the appropriate modifier(s) being used for billing, as applicable.
Sections 4A, 5A, 6, and 7 must be completed by prescribing provider.	
Sections 4A, 5A	Enter the length of need (in months).
Section 5A	Enter the monthly quantity and the number of refills (in months).
Section 6	Enter the medical justification for all items listed above. Include (if applicable) settings, therapeutic outcomes, and previous treatment plans. Attach any applicable supporting medical documentation (e.g., lab tests, etc.).
Section 7	The member's prescribing provider listed in Section 2 of this form must review all information completed on and attached to this form, and must sign and date the form. By signing the form, the prescribing provider is making the certifications contained above the signature line. The form must be signed by the member's prescribing provider, who must be either the member's physician (MD), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). The prescribing provider must check the applicable credential(s). **Wet signatures or electronic signatures as defined in Durable Medical Equipment Bulletin 31 are acceptable. Please also refer to Section 8 below for information and requirements for wet and electronic signatures.**

Section 8	The provider of DME must sign and enter the date the form was completed. By signing the form, the provider is making the certifications contained above the signature line. **The signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of a legal entity (if the provider of DME is a legal entity), is not acceptable. Wet signatures or electronic signatures as defined above and in Durable Medical Equipment Bulletin 31 Provider Bulletin are acceptable.** MassHealth will accept provider signatures executed by an authorized signatory in any of the following formats. 1. Traditional "wet signature" (ink on paper) 2. Electronic signature that is either: a. Hand-drawn using a mouse or finger if working from a touch screen device b. An uploaded picture of the signatory's hand-drawn signature 3. Electronic signatures affixed using a digital tool such as, but not limited to: a. Adobe Sign b. DocuSign If a provider is using an electronic signature, the signature must be visible, include the signatory's name and title, and must be accompanied by a signature date. One of the following notations must be included to indicate that the signatory's name, typically applied in typed format, was electronically signed. • Electronically signed by • Authenticated by • Approved by • Completed by • Finalized by • Signed by • Validated by • Sealed by

If you have any questions about how to complete this form, please contact the MassHealth LTSS Provider Service Center at **(844) 368-5184.**