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

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

MassHealth

**This form must be completed by the durable medical equipment (DME) provider, except where otherwise indicated.**

## SECTION 1

| | | | |
|---|---|---|---|
| Member name | | Date of delivery | |
| Address | | Telephone | |
| MassHealth ID | Date of birth | Height | Weight |
| Primary ICD code | Description | | |
| Secondary ICD code | Description | | |

## SECTION 2

| | |
|---|---|
| Ordering practitioner's name | NPI |
| Address | |
| Telephone | Fax |

## SECTION 3

| | |
|---|---|
| Name of DME provider | NPI |
| Address | |
| Telephone | Fax |

**SECTION 4** For DME only
**(Use Section 4B for additional listings.)**

| Items requested | HCPCS code | Modifiers |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

**SECTION 4A**
**(Must be completed by the ordering practitioner or their employee.)**

**Length of need**

1. .....
2. .....
3. .....
4. .....
5. .....
6. .....

**SECTION 5** For medical supplies only

| Items requested | HCPCS code | Modifiers |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**SECTION 5A**
**(Must be completed by ordering practitioner or their employee.)**

| Quantity monthly | Number of refills |
|---|---|
| | |
| | |
| | |
| | |

**SECTION 6** **(Must be completed by the ordering practitioner or their employee.)**
**Medical justification for requested item(s) along with any settings, therapeutic outcomes, and previous treatment plans (if applicable). Please attach any pertinent documentation (lab tests, etc.).**

.....
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.....
.....

Member name

## SECTION 7

### Ordering practitioner's attestation, signature, and date

### (For more information, refer to Durable Medical Equipment Bulletin 31 and instructions for Section 7.)

I certify under the pains and penalties of perjury that I am the ordering practitioner 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.

..... .....

Ordering practitioner's signature Date

(Wet and electronic signatures are acceptable. Signature and date stamps, or the signature of anyone other than ordering practitioner or their employee, are not acceptable.)

..... .....

For wet signature, print legal name of ordering practitioner. Date

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

## 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. | | |
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| 23 | | |
| 24 | | |

## SECTION 8

### DME provider's attestation, signature, and date

### (For more information, refer to Durable Medical Equipment Bulletin 31 and instructions for Section 8.)

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 DME provider or, in the case of a legal entity, duly authorized to act on behalf of the DME 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.

..... .....

DME provider's signature Date

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

..... .....

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

Print Reset

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

Sections 1–5 and 8 must be completed by the DME provider.
Sections 4A, 4B, 5A, 6, and 7 must be completed by the member's ordering practitioner.

| | |
|---|---|
| **Instructions for using this form** | DME providers should use this form when obtaining a prescription and letter of medical necessity from the member's ordering practitioner, 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, height, weight, ICD code(s), and diagnosis that pertain to the items being dispensed. |
| **Section 2** | Enter the ordering practitioner'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. DME providers 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, and 6, must be completed by the ordering practitioner or their employee. Section 7 must be completed by the ordering practitioner.** | |
| **Section 4A** | 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 (lab tests, etc.). |
| **Section 7** | The member's ordering practitioner 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 ordering practitioner is certifying the information contained above the signature line. The form must be signed by the member's ordering practitioner, who must be either the member's physician (MD), nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). The ordering practitioner 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 DME provider must sign and enter the date the form was completed. By signing the form, the DME provider is certifying the information contained above the signature line. **The signature of anyone other than the DME provider, or a person legally authorized to sign on behalf of a legal entity (if the DME provider is a legal entity), is not acceptable. Wet signatures or electronic signatures as defined above and in Durable Medical Equipment Bulletin 31 are acceptable.** |

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