Documentation of Medical Necessity Form

DOCUMENTATION OF MEDICAL NECESSITY

I. PATIENT INFORMATION				II. PROVIDER INFORMATION	
1. DATE OF BIRTH	2. SEX	3. AGE	4. MEDICAID IDENTIFICATION NO.	9. PROVIDER NUMBER	10. PHONE NO. (INCLUDING AREA CODE)
5. PATIENT NAME (LAST, FIRST, MI)				11. PROVIDER NAME AND ADDRESS	
6. STREET ADDRESS					
7. CITY, STATE, ZIP CODE					
8. PHONE NUMBER					

III. SERVICE INFORMATION

12. SUMMARY OF HISTORY (PHYSICAL EXAMINATION, LABORATORY, X-RAY STUDIES, PRESCRIPTIONS AND OTHER APPLICABLE DOCUMENTATION MUST BE SUPPLIED IN SUFFICIENT DETAIL TO SATISFY THE MEDICAL NECESSITY FOR THE PRESCRIBED SERVICE. ADDITIONAL DOCUMENTATION MAY BE ATTACHED WHEN NECESSARY.)

13. IF THIS SERVICE WAS PERFORMED OUT-OF-STATE PLEASE PROVIDE A BRIEF JUSTIFICATION STATEMENT

14. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

____ _____________________________________

SIGNATURE OF PHYSICIAN OR PROVIDER DATE

IV. APPROVAL (FOR AGENCY USE ONLY)

15. COMMENTS/EXPLANATION

APPROVED: YES_____ NO_____ ___________________________ ____

DATE SIGNATURE

NOTE: APPROVAL DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY AND WYOMING BENEFIT LIMITATIONS. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

HCF-04