

(WEB)
CERTIFICATE OF MEDICAL NECESSITY

CG

POWER OPERATED VEHICLE (POV)

SECTION A		Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___
PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER (____)____-____-____ HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER INDEPENDENT LIVING AIDS of GEORGIA 6002 Veterans Parkway Columbus, GA 31909 Fax: (706) 327-2099 (706) 327 - 5613 NSC # 1149340001
PLACE OF SERVICE <u>12</u> NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODE <u>E1230NU</u>	PT DOB ___/___/___; Sex ___ (M/F); HT. ___(in.); WT. ___(lbs.) PHYSICIAN'S NAME, ADDRESS, TELEPHONE and UPIN NUMBER (____)____-____-____ UPIN # _____

SECTION B Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)	DIAGNOSIS CODES (ICD-9): _____
ANSWERS	ANSWER QUESTIONS 6 - 14 FOR POWER OPERATED VEHICLE (POV) (Circle Y for Yes, N for No, or D for Does Not Apply)
	Questions 1 - 5, and 9 - 11, reserved for other or future use.
Y N D	6. Does the patient require a POV to move around in their residence?
Y N D	7. Have all types of manual wheelchairs (including lightweights) been considered and ruled out?
Y N D	8. Does the patient require a POV <u>only</u> for movement outside their residence?
Y N D	12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	13. Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	14. Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
 NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (See Instructions On Back)

HCPCS CODE	QTY	DESCRIPTION OF EQUIPMENT	SUPPLIER'S CHARGE	MEDICARE ALLOWANCE
E1230NU	1	POWER OPERATED VEHICLE	\$ 2395.00	\$ 2250.60

SECTION D Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___/___/___ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)