DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY
CMS-854 — CONTINUATION FORM

DME MAC 11.02

PATIENT NAME	PATIENT HICN

SECTION C Narrative Description of Equipment and Cost *(continued)*

(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.)

SECTION D PHYSICIAN Attestation and Signature/Date

I certify that I am the treating 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 _____/_____/_____

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY SECTION C CONTINUATION FORM (CMS-854)

SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Provide (1) a narrative description of the item(s) ordered, as well as all options, accessories; (2) the product, model and serial number of the product being delivered (if applicable); (3) the supplier's charge for each item, option, accessory; and (4) the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies(1) the CMN which he/she is reviewing includes Sections A, B, C and D;: (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see *http://www.medicare.gov/* for information on claim filing.