DLN _____ Medicaid ID _____ Individual Name _____

Attachment. NFSS Therapist, Referring Physician and NF Administrator CMWC/DME Signature Page

To be completed by respective parties, as applicable, and uploaded by the NF if Type of Service is CMWC, CMWC Assessment Only, DME or DME Assessment Only

Therapist Certification

I certify the resident's living arrangement is accessible to the CMWC/DME items; there are ramps available (if applicable) in the resident's living environment; and the CMWC/DME item(s) being supplied under this request is/are consistent with the assessment and that the requested item(s) is/are appropriate and can safely be used in the resident's environment when used as described in the CMWC/DME Assessment.

Indicate CMWC or DME Item (Select only one):

- ☐ CMWC
- ☐ Gait Trainer
- ☐ Orthotic Device
- ☐ Positioning Wedge
- ☐ Prosthetic Device
- ☐ Special Needs Car Seat or Travel Restraint
- ☐ Specialized or Treated Pressure-Reducing Support Surface Mattress
- ☐ Standing Board/Frame

B0100A. Therapist's First Name (Printed)

B0100B. Therapist's Last Name (Printed)

Therapist's Signature

B0700. Therapist's Signature Date

Referring Physician Certification
To be completed by Physician if Type of Service is CMWC or DME
Skip if Type of Service is CMWC Assessment Only or DME Assessment Only

By signing this form, I hereby attest that the information provided on the NFSS request is consistent with the determination of the resident's current medical necessity and prescription. By prescribing the identified CMWC/DME item(s), I certify the prescribed item is appropriate and can be safely used in the resident's environment when used as prescribed.

B2400A. Physician's Last Name (Printed)

Physician's Signature

B2400F. Physician's Signature Date

NF Administrator Acknowledgment
To be completed by NF Administrator if Type of Service is CMWC or DME.

I acknowledge that I have been made aware of the resident's CMWC/DME request. I understand that appropriate facility staff or a contract therapist has provided the resident assessment information included in this request to support the resident's needs specific to the item(s) requested and that the item(s) can be safely used in the resident's environment when used as presribed.

NF Administrator's First Name (Printed)

NF Administrator's Last Name (Printed)

NF Administrator's Signature

NF Administrator's Signature Date