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

Performance Care

Form Approved OMB
No. 0938-0679
Expires 02/2024

CERTIFICATE OF MEDICAL NECESSITY
CMS-846 — PNEUMATIC COMPRESSION DEVICES

DME 04.04B

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____	**PERFORMANCE CARE** **121 Fairway Dr. Nashville, TN 37214** **Phone: 615-647-7828 - NPI: 1073939526**

PLACE OF SERVICE _____	Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____(lbs
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # (__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

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 CODE(S): _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1–5 FOR PNEUMATIC COMPRESSION DEVICES (Check Y for Yes, N for No, Unless Otherwise Noted)
❑ Y ❑ N	1. Does the patient have chronic venous insufficiency with venous stasis ulcers?
❑ Y ❑ N	2. If the patient has venous stasis ulcers, have you seen the patient regularly over the past six months and treated the ulcers with a compression bandage system or compression garment?
❑ Y ❑ N	3. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?
❑ Y ❑ N	4. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?
❑ Y ❑ N	5. Has the patient had lymphedema since childhood or adolescence?

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

SECTION C: Narrative Description of Equipment and Cost *- SUPPLIER COMPLETES THIS SECTION -*

(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 _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

Form CMS-846 (06/19)

FAX TO PERFORMANCE CARE AT 615-953-7946