**CMN INFORMATION**

1. Provide Begin Date On CMN:
2. Provide Date of Physician/Nurse Practitioner Signature:
3. Provider Contact Name:
4. Provider Contact Number:
5. Date of Injury/Illness/Surgery:
6. Level of Need:
   1. Acute Need: Yes/No
   2. Chronic or long-term need: Yes/No
7. Is this a Retro Review: Yes / No
8. Please List Specific Impairment Including mobility and functional limitations:
9. Describe what level of assistance is required for each impairment:
10. List specialized equipment the patient requires:
11. List Therapeutic Interventions (Medications, Nutrition, Coping Skills Etc.):
12. List Mobility Impairments:
13. List Endurance impairments:
14. List Activity restrictions:
15. List Respiration Impairments:
16. List Speech Impairments:
17. Does patient have Any Skin Breakdown: Yes / No
    1. If yes, explain in Atrezzo Web portal under Clinical Information
18. Is Assistance Required With ADL’s: Yes / No
    1. If yes, explain in Atrezzo Web portal under Clinical Information
19. Are Nutritional Supplements Required: Yes / No
    1. If yes, If yes, explain in Atrezzo Web portal under Clinical Information
20. Is The Item Suitable For Use In The Home: Yes / No
    1. If yes, If yes, explain in Atrezzo Web portal under Clinical Information
21. Does The Caregiver Demonstrate A Willingness / Ability to Use The Equipment:

Yes / No

* 1. If yes, If yes, explain in Atrezzo Web portal under Clinical Information

1. Is Equipment for:
   1. Rental: Yes/No
   2. Purchase: Yes/No
2. Add in notes: The Actual Cost per Unit and/or Usual and Customary as applicable
3. Add in Notes: Total Dollars requested
4. Clinical Information: Comment box in Atrezzo web portal for entering specific information as noted in numbers 8 through 24 on this document

**Out of State Providers**

1. **Please select one of the four questions which best meets the reason you are requesting Out of State Provider Services and specify how the request meets the selected reason:**

**Services provided out of state for circumstances other than these specified reasons shall not be covered.**

The medical services must be needed because of a medical emergency;

Medical services must be needed and the Member's health would be endangered if he were required to travel to his state of residence;

The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

It is the general practice for Members in a particular locality to use medical resources in another state.

Explain selected response:

1. Enrolled in Virginia Medicaid:  **Yes  No**

**Out of state providers may enroll with Virginia Medicaid by going to:**

<https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box.  **It may take up to 10 business days to become a Virginia participating provider.**