**CMN INFORMATION**

**NOTE** – Beginning 7/1/2010, DMAS will change the Billing units for Incontinence supplies. Requests for these supplies with dates prior to 7/1/2010 will be in Cases. Requests for these supplies with dates **on** **or after 7/1/2010** will be entered as each item/unit. Reference DMAS Memo dated 1-28-2010 and DMAS Memo dated 6/17/2010.

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. Describe what level of assistance is required for each impairment:
9. List specialized equipment the patient requires:
10. List Therapeutic Interventions (Medications, Nutrition etc.):
11. List Mobility Impairments:
12. List Endurance Impairments:
13. List Activity Restrictions:
14. Does Patient Have Any Skin Breakdown: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
15. Is Assistance Required With ADL’s: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
16. Are Nutritional Supplements Required: Yes / No
	1. If yes, explain in Atrezzo Connect Clinical Information note box
17. Is The Item Suitable For Use In The Home: Yes / No

If yes, explain in Atrezzo Connect Clinical Information note box

1. Explain member’s:
	1. Incontinent condition and diagnosis
	2. Frequency of Use
	3. How were needs previously met
	4. Degree of incontinence (if known)
	5. Functional limitations/symptoms
2. Comment box in Atrezzo for entering specific information as noted in numbers 8 through 18e on this document
3. Comment box in Atrezzo for entering specific treatment information noted in numbers 8 through 18e 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.**