AMERICAN SAMOA MEDICAID STATE AGENCY
OFFICE OF THE GOVERNOR
PO BOX 998383
AMERICAN SAMOA 96799
PH: (684) 699-4777 | FAX: (684) 699-4780

DMEPOS Physician Order Form

See instructions for completing the DMEPOS Physician Order Form. This order form cannot be accepted beyond 90 days from the date of the physician's signature.

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization statement.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes free, correct, complete and accurate information; does not contain any misrepresentation; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the fact, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with American Samoa Medicaid State Plan.

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter under that the payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statement of documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable Federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of provider's Medicaid enrollment and/or personal exclusion from the American Samoa Medicaid Program.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the American Samoa Medicaid State Plan and they agree and consent to the Certification above and to the American Samoa Medicaid Provider Agreement Terms and Conditions.

DMEPOS Supplier: ☐ **Agree**

Prescribing Physician: ☐ **Agree**

DMEPOS Physician Order Form

SECTION I: Requested DMEPOS

This section was completed by (check one): ☐ **Requesting Physician** ☐ **DMEPOS Supplier**

Patient Information

Patient Name	*Hospital Number*	*Date of Birth*

Is this Patient Medicaid Eligible?	*If yes, please indicate eligibility status of Medicaid patient*			
☐ Yes ☐ No	☐ US Citizen	☐ US National	☐ US Permanent Resident	☐ Lawfully Present Child under 21 ☐ AS Permanent Resident (*Dual-Eligible Beneficiaries Only*)

Supplier Information

Name	*Telephone*	*Fax Number*

Address	*NPI*	*Provider Medicare Identification Number*

By my signature below, I certify that the services being supplied under this order are consistent with the physician's determination of medical necessity and prescription. The prescribed items are appropriate and can safely be used in the client's home when used as prescribed.

DMEPOS Provider Representative Signature	*DMEPOS Provider Representative Name*	*Date*

Prescribing Physician Information

Name	*Telephone*	*Fax Number*

Item Number	HCPCS Code	Description of DMEPOS	Qty	Price	Beyond Qty. Limit?[1]	Custom Item?
1					☐Y ☐N	☐Y ☐N
2					☐Y ☐N	☐Y ☐N
3					☐Y ☐N	☐Y ☐N
4					☐Y ☐N	☐Y ☐N
5					☐Y ☐N	☐Y ☐N
6					☐Y ☐N	☐Y ☐N
7					☐Y ☐N	☐Y ☐N
8					☐Y ☐N	☐Y ☐N

1. If "Yes", additional documentation must be provided to support determination of medical necessity.

SECTION II: Diagnosis and Medical Need Information

The prescribing physician must fill out this section.

Item Number	Diagnosis	Brief Diagnosis Description	Complete Justification for determination of medical necessity for requested item(s)[2]

2. Each item requested in Section I must have a correlating diagnosis and medical necessity justification. Enter all item numbers from the table in Section I that pertain to each diagnosis. A range of item numbers may be entered.

Note: The "Date Last Seen" and "Duration of Need" items must be filled in.	*Date Last Seen by Physician*
Duration of need for DME: _____ month(s)	*Duration of need of supplies:* _____ month(s)

By signing this form, I hereby attest that the information in Section "I", with the exception of the DME provider's signature, was complete at the time of my signature and is consistent with the determination of the client's current medical necessity and prescription. By prescribing the identified DMEPOS, I certify the prescribed items are appropriate and can be safely used in the client's home when used as prescribed.

Signature and attestation of prescribing physician	*NPI*	*Date*

SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE

FOR AMERICAN SAMOA MEDICAID STATE AGENCY USE ONLY

By signature below, I hereby attest that the information in Section "I" and Section "II" is true, accurate and completed to the best of my knowledge.

Medicaid Authorized Representative Name

Medicaid Authorized Representative Signature	*Time*	*Date Received*

Medicaid Director Comments:	☐ Approved ☐ Denied

Medicaid Director Signature	*Date*