Wyoming Medicaid Guidelines

CompuMed® Automated Medication Dispenser

For **Wyoming Medicaid patients** needing a CompuMed medication management system, please fill out the following:

- **Certificate of Medical Necessity** (CMN)
- **Prescription** for a CompuMed written on the doctor's pad

and send to us at:

fax: 888-722-8217 *or*
e-mail: stevec@compumed.com

Once we receive these forms, we send them in for Prior Authorization. Once that is received, a CompuMed is sent to the address you give us (i.e. the patient's home or home health agency, etc.).

Please let us know which medication management system your patient needs - the ***Standard CompuMed*** or the ***Enhanced Security CompuMed***.

If you have questions, please call us at 1-800-722-4417 or 307-868-2555.

Thank you!

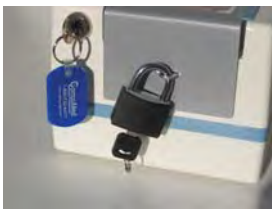
Standard CompuMed

The Standard CompuMed is lockable and secure - for willing but forgetful patients.

For those who ***forget.***

Enhanced Security CompuMed

The Enhanced Security CompuMed adds a metal plate, hasp and lock to the standard CompuMed unit. Security is increased for those who tend to abuse medication.



For those who ***remember too well.***

Certificate of Medical Necessity

CompuMed Automated Medication Dispenser

HCPC Code S5185 **NAICS** 334510 **CAGE** 5NFF3

Patient

Name _____

Birthday ___/___/_____ ___M ___F

Address _____

City, ST Zip _____

Phone ( ) -

Medicaid # _____

Medicare # _____

Date ___/___/___ evaluated face-to-face ___/___/___ prescribed

Service Provider (Physician, Agency, et al.)

Name _____

Address _____

City _____

Zip (9 digits) _____

Phone ( ) -

NPI # _____

Contact Person _____

Contact Phone ( ) -

Diagnosis Code

_____

_____

_____

Description

_____

_____

_____

Medications used by patient (please include an attachment for additional medications)

Medication	Dosage	Frequency per day

Clinical Notes (Describe why medication management is necessary. Attach additional notes if needed.)

_____

_____

_____

_____

_____

_____

Physician certification

To the best of my knowledge, the above information is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. I authorize the release of any medical or other information necessary to process this claim.

_____ _____

Physician signature Date

Rev 07/16

Please include a prescription