The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

Medical Necessity Review Form for Absorbent Products

If you choose to submit this form with your request for prior authorization, the form must be completed by the prescriber and have a copy of the prescription attached. Please refer to the instructions for completing this form provided at the end of this document. Please print or type all sections.

1. Member's name:

2. Member's MassHealth ID no.:

3. Member's DOB:

4. Member's address:

5. Primary diagnosis name and ICD-9-CM code:

6. Secondary diagnosis name and ICD-9-CM code:

7. Signs and symptoms of incontinence
- ☐ Stress incontinence
- ☐ Urge incontinence
- ☐ Mixed incontinence
- ☐ Overflow incontinence
- ☐ Total incontinence
- ☐ Other (specify): ____________

8. Diagnostic tests (Attach results.)
- ☐ Urinalysis
- ☐ Urine culture and sensitivity
- ☐ Post-void residual determination
- ☐ Other (specify): ____________

9. Risk factors (Use attachment as needed.)
- ☐ Impaired mobility
- ☐ Impaired cognitive function
- ☐ Neurological disorders (specify): ____________
- ☐ Chronic disease (specify): ____________
- ☐ Urological disorders (specify): ____________
- ☐ Other (specify): ____________

10. Possible reversible factors
- ☐ Symptomatic urinary tract infection
- ☐ Environmental conditions
- ☐ Medical conditions
- ☐ Medications
- ☐ Other (specify): ____________

11. Type of treatment initiated (Attach explanation.)
- ☐ None
- ☐ Behavioral
- ☐ Pharmacological: ____________
- ☐ Surgical
- ☐ Other (specify): ____________

12. Expected treatment outcome (Attach explanation.)
- ☐ Expected to improve within 3 months
- ☐ Expected to improve within 6 months
- ☐ Expected to improve within 9 months
- ☐ Expected to improve within 12 months
- ☐ Not expected to improve

13. General Information: Height: inches Weight: lbs.

14. Location where member will use item: ☐ Home ☐ Work ☐ Other (specify):

15. Duration of need (number of months):

16. No. of refills:

17. Absorbent product(s)				**Quantity per month**	**Size (S, M, L, XL)**
☐ Diapers (Check one.):	☐ child-sized	☐ youth-sized	☐ adult-sized	________	________
☐ Briefs (Check one.):	☐ child-sized	☐ youth-sized	☐ adult-sized	________	________
☐ Liner/shield (Check one.):	☐ disposable	☐ reusable		________	________
☐ Underpad (Check one.):	☐ disposable	☐ reusable		________	________
☐ Other (specify): ____________				________	________

18. DME provider

Company name:	MassHealth provider no. (if available):
Address:	Telephone no. (if available):

19. Prescriber	**20. Person completing form on behalf of prescriber**
Name:	Name:
Address:	Title:
Telephone no.:	Telephone no.:
MassHealth provider no. :	Organization:
Provider UPIN:	

21. Attestation: I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be subject to civil or criminal liability.

______________________________ ______________________________
Prescriber attestation (signature) **Date** (mm/dd/yy)

Instructions: Complete all applicable fields on the form. Print or type all sections.

Item 1	Member's name	Enter the member's name as it appears on the MassHealth card.
Item 2	Member's ID no.	Enter the member's MassHealth identification number, which appears beside the member's name on the MassHealth card.
Item 3	Member's DOB	Enter the member's date of birth in month/day/year order.
Item 4	Member's address	Enter the member's permanent legal address (street address, town, and zip code).
Item 5	Primary diagnosis	Enter the primary diagnosis name and ICD-9-CM code that describe the incontinence signs and symptoms for which the absorbent product is being requested.
Item 6	Secondary diagnosis	Enter the secondary diagnosis names and ICD-9-CM codes (up to three codes) that further describe the medical conditions associated with the primary diagnosis. Enter "N/A" if not applicable.
Item 7	Signs and Symptoms of Incontinence	Place a checkmark beside the signs and symptoms of incontinence associated with the primary diagnosis. If checking "Other," specify the signs and symptoms in the space provided (for example, fecal).
Item 8	Diagnostic tests	Place a checkmark beside all diagnostic tests that apply. If checking "Other," specify the name of test(s) in the space provided. Attach test results for items checked.
Item 9	Risk factors	Place a checkmark beside all risk factors that may affect incontinence treatment. If checking "Other," specify the factors in the space provided. Attach clinical information for items checked.
Item 10	Possible reversible factors	Place a checkmark beside all possible reversible factors that may affect incontinence treatment. If checking "Other," specify the factors in the space provided. Attach clinical information for items checked.
Item 11	Type of treatment initiated	Place a checkmark beside the type(s) of treatment that have been tried to manage incontinence. If checking "Other," specify the treatment in the space provided. Attach an explanation of responsiveness to treatment for all items checked.
Item 12	Expected treatment outcome	Place a checkmark beside the item that describes the member's prognosis for improvement. Attach an explanation pertinent to the item checked.
Item 13	General Information	Enter the member's height in inches and weight in pounds.
Item 14	Location where member will use item	Place a checkmark beside all locations where the member will use the item. If checking "Other," specify the location in the space provided.
Item 15	Duration of need	Enter the total number of months that the prescriber expects the member will require use of the items requested. Specify 1 to 99 months, where 99 indicates lifetime use.
Item 16	No. of refills	Enter the amount of monthly refills for this prescription.
Item 17	Absorbent product(s) requested	Place a checkmark beside the absorbent product(s) being requested. If checking "Other," specify the type in the space provided. For each product, specify the quantity per month, and the size needed (S = small; M = medium; L = large; XL = extra large).
Item 18	DME provider	Enter the company name and address of the provider who will supply the absorbent product(s) being requested. If available, also provide the DME provider's telephone number and MassHealth provider number.
Item 19	Prescriber	Enter the physician's/clinician's name, address, and telephone number where he or she can be contacted if more information is needed. Include the prescriber's MassHealth provider number, or if the prescriber is not a MassHealth provider, enter the prescriber's unique physician identification number (UPIN).
Item 20	Person completing form on behalf of prescriber	If a clinical professional other than the treating clinician (for example, home health nurse, physical therapist, or urologist) or a physician employee answers any of the items on this form, he or she must print his or her name, professional title, and name of employer (organization) where indicated.
Item 21	Attestation	The prescriber must attest that the clinical information provided on the form is accurate and complete to the best of the prescriber's knowledge by signing this field.

Note: Prior-authorization requests with incomplete medical necessity documentation may be returned for more information or denied. Please refer to the *MassHealth Guidelines for Medical Necessity Determination for Absorbent Products* for further information about submitting required clinical documentation.