Certification of Need for Services

Submit this form to fax: (833) 832-1015
Obtaining authorization does not guarantee payment. The plan retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of the service, correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

☐ Initial authorization/initial clinical assessment/POC		☐ Reauthorization/plan of care	
Admission date:		Request date:	
Authorization START date:		Authorization END date:	

Provider(s) Information					
Program / Facility:		Contact Person:		Medicaid provider #:	
Phone:		Fax:		Facility NPI:	
Ordering Physician:				Provider NPI:	

Member Information					
Name:				Date of birth:	
Address:				Home phone:	
State:		Zip code:		Mobile phone:	
Additional contact		Relationship:		Phone:	

Physician and evaluation team certification of need for services	
I have assessed the client and certify that the client meets the PRTF level of care requirements, according to CMS regulations, including:	
☐ Ambulatory care resources available in the community do not meet the treatment needs of the individual.	
☐ Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician.	
☐ The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.	
Physician signature	
Evaluating team member signature	
Evaluating team member signature	
Evaluating team member signature	
Parent/legal guardian signature	