



## Nursing Facility Post Eligibility Treatment of Income (PETI) Medical Necessity Certification Form

I certify that I consider the supplies and or services included in this request to be medically necessary and that there are no medical or cognitive contraindications to providing these supplies and or services.

\_\_\_\_\_  
**Physician's Signature Required**      License#      Date

\_\_\_\_\_  
 Physician's Print Name

***Note:** Only a physician's signature is required to verify medical necessity. A Physician's Assistant (P.A.), Nurse Practitioner (N.P.), or Registered Nurse (R.N.) cannot sign for the physician.*

\_\_\_\_\_  
 Acupuncturist's Signature      Print Name      License#      Date

\_\_\_\_\_  
 Audiologist's Signature      Print Name      License#      Date

\_\_\_\_\_  
 Dental Provider's Signature      Print Name      License#      Date

\_\_\_\_\_  
 Vision Provider's Signature      Print Name      License#      Date

\_\_\_\_\_  
**Signature of Client or Responsible Party**      Relationship      Date

***Note:** a Verbal consent is not an allowable option I agree to the purchase of the supplies and or services covered by this request. I understand the NF PETI PAR may not cover the entire cost and I can be responsible.*





## NURSING FACILITY PETI CHECKLIST

Complete appropriate checklist for each request

### Health Insurance Premiums

- Resident's monthly patient payment - \$ \_\_\_\_\_
- Medical Necessity Form completed with:
  - Signature of Attending Physician
  - Signature of Client Responsible party
- Verification Statement of premium monthly amount
- Insurance Card Copies front and back
- Months of coverage being requested: \_\_\_\_\_  
not to exceed 12 months                      From                      To

### Acupuncture

- Resident's monthly patient payment - \$ \_\_\_\_\_
- Medical Necessity Form completed with:
  - Signature of Attending Physician
  - Signature of Client Responsible party
  - Signature of Provider
- Provider's invoice with procedure codes and fees
- Prescription/Dr. Orders with number of treatments

### Dental

- Resident's monthly patient payment - \$ \_\_\_\_\_
- Medical Necessity Form completed with:
  - Signature of Attending Physician
  - Signature of Client Responsible party
  - Signature of Provider
- Provider's invoice with procedure codes and fees
- DentaQuest EOB verifying \$1500 Medicaid benefit is exhausted

### Hearing

- Resident's monthly patient payment - \$ \_\_\_\_\_
- Medical Necessity Form completed with:
  - Signature of Attending Physician
  - Signature of Client Responsible party
  - Signature of Provider
- Provider's invoice with procedure codes and fees
- Audiogram – performed by licensed audiologist no older than one year (for Hearing Aids only)  
*(Note: BC HIS is not an acceptable license to perform the audiogram)*

### Vision

- Resident's monthly patient payment - \$ \_\_\_\_\_
- Medical Necessity Form completed with:
  - Signature of Attending Physician
  - Signature of Client Responsible party
  - Signature of Provider
- Provider's invoice with procedure codes and fees