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 __________________ License# ______ Date ______

Audiologist’s Signature __________________ License# ______ Date ______

Dental Provider’s Signature __________________ License# ______ Date ______

Vision Provider’s Signature __________________ 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.

Contact Information: List contact information of who created this claim.

Name __________________ Telephone Number ______ Date ______

Revised September 2022
NURSING FACILITY PETI CHECKLIST

Complete the 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)

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
☐ Resident’s current eye prescription