COLORADO
Department of Health Care Policy & Financing

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

I certify that I consider the supplies, and our 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 Information - Required	
Print Name:	License #:
Signature:	Date:

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.

Other Providers			
Acupuncturist			
Print Name:	License#:	Signature:	Date:
Audiologist			
Print Name:	License#:	Signature:	Date:
Dental Provider			
Print Name:	License#:	Signature:	Date:
Vision Provider			
Print Name:	License#:	Signature:	Date:

Member Information		
Print Name:	DOB:	Medicaid ID#:
Member Signature or Responsible Party:	Relationship:	Date:

Note: *Verbal consent is **not** an allowable option.* I agree with 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.

Person completing this form	
Name:	Phone:

Nursing Facility PETI Checklist

Complete the checklist for the service(s) requested. Including full and complete information can help to ensure the claim is not denied.

Medical Health Insurance Service 0999

- ☐ Resident's monthly patient payment - $_____
- ☐ Medical Necessity Form completed with:
  - ☐ Signature and Printed Name of Attending Physician
  - ☐ Signature of Service Provider
  - ☐ Signature of Member or Responsible Party
- ☐ Billing Statement to Identify Type of Plan and Monthly Premium Fee
- ☐ Insurance Card Copies front and back – Date Span for Period _____

Acupuncture Treatment Service 0949

- ☐ Resident's monthly patient payment - $_____
- ☐ Medical Necessity Form completed with:
  - ☐ Signature and Printed Name of Attending Physician
  - ☐ Signature of Service Provider
  - ☐ Signature of Member or Responsible Party
- ☐ Provider's invoice with CPT codes and fees
- ☐ Prescription, Dr. Orders with number of treatments

Dental Service 0969

- ☐ Resident's monthly patient payment - $_____
- ☐ Medical Necessity Form completed with:
  - ☐ Signature and Printed Name of Attending Physician
  - ☐ Signature of Service Provider
  - ☐ Signature of Member or Responsible Party
- ☐ Provider's invoice with CDT procedure codes and fees
- ☐ Dental Quest EOB statement verifying Medicaid benefit service

Audiology Service 0479

- ☐ Resident's monthly patient payment - $_____
- ☐ Medical Necessity Form completed with:
  - ☐ Signature and Printed Name of Attending Physician
  - ☐ Signature of Service Provider
  - ☐ Signature of Member or Responsible Party
- ☐ Provider's invoice with CPT-HCPCS procedure codes and fees
- ☐ Audiogram current test performed by licensed audiologist

Vision Service 0962

- ☐ Resident's monthly patient payment - $_____
- ☐ Medical Necessity Form completed with:
  - ☐ Signature and Printed Name of Attending Physician
  - ☐ Signature of Service Provider
  - ☐ Signature of Member or Responsible Party
- ☐ Provider's invoice with CPT procedure codes and fees
- ☐ RX current eye prescription