



**ROUTINE MEDICAL ASSESSMENT FOR REQUIREMENT OF THE  
MEDICAID WAIVERS FOR ADULTS WITH DEVELOPMENTAL DISABILITIES**  
See back of form for instructions for completion

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

RE: Name \_\_\_\_\_

Medicaid ID # \_\_\_\_\_

Date of birth \_\_\_\_\_

\_\_\_\_\_ is applying for / receiving **(circle one)** for one of the home and community based (HCBS) waivers for adults with developmental disabilities (DD). In order to become eligible or maintain ongoing eligibility, the HCBS waiver programs for adults with DD require an initial physical exam/medical assessment and then an annual medical assessment thereafter.

Please submit your claim directly to Medicaid. This form may be attached to your Medicaid paper claim for \_\_\_\_\_'s routine medical assessment on \_\_\_/\_\_\_/\_\_\_\_. If you file electronically, please note either "DD Waiver applicant" or "DD Waiver client" on the 837P, Loop 2300, NTE Claim note, NTE02.

Medicaid claims should be billed using the appropriate preventative medicine code according to the client's age with a diagnosis of V70.3.

Questions regarding submitted claims for these routine medical assessments should be addressed to the Medicaid Inquiry Line at 471-9128 or outside of Lincoln at (877) 255-3092.

If you have any questions regarding this appointment, please contact me.

\_\_\_\_\_  
Name of person scheduling the appointment

\_\_\_\_\_  
Title or relationship to client

\_\_\_\_\_  
Phone Number

Instructions for Completing "Routine Medical Assessment for Requirement of the  
Medicaid Waivers for Adults with Developmental Disabilities"

Use: This form is used by Nebraska Department of Health and Human Services staff, DD provider agency staff, the client, or family members when scheduling an appointment for clients applying for or receiving Medicaid DD waiver services, to facilitate accurate claims.

Scheduling an appointment: Prior to scheduling, confirm that the client is applying for or receiving services through one of the HCBS waiver programs. This information is documented in the Individual Program Plan or may be obtained from the individual's DD service coordinator. Verbally inform the medical practitioner's office that the routine medical assessment is an eligibility requirement for the provision of services through one of the HCBS waiver programs.

Completion: This form is completed annually, or as directed by the client's physician. This form is completed (all blanks filled in) by the individual who schedules the appointment and is provided to the physician's office staff prior to or at the time of the appointment. Per HIPAA rules this form cannot be e-mailed via the Internet.

TO: Enter the name of the Physician or Clinic.  
FROM: Enter your name or the name of the individual who will be assisting or accompanying the individual.  
RE: Enter the client's full name.  
Enter the client Medicaid ID #  
Enter the client date of birth

(Client name) is applying for / receiving (circle one) for one of the HCBS waiver programs for adults with DD. In order to become eligible or maintain ongoing eligibility, the HCBS waiver programs for adults with DD require an initial physical exam/medical assessment and then an annual medical assessment thereafter.

Please submit your claim directly to Medicaid. This form may be attached to your Medicaid paper claim for (client's name) routine medical assessment on (date of service). If you file electronically, please note either "DD Waiver applicant" or "DD Waiver client" on the 837P, Loop 2300, NTE Claim note, NTE02.

Medicaid claims should be billed using the appropriate preventative medicine code according to the client's age with a diagnosis of V70.3.

Questions regarding submitted claims for these routine medical assessments should be addressed to the Medicaid Inquiry Line at 471-9128 or outside of Lincoln at (877) 255-3092.

If you have any questions regarding this appointment, please contact me.

\_\_\_\_\_ (Person scheduling the appointment on behalf of the client)

\_\_\_\_\_ (Title or relationship to client)

\_\_\_\_\_  
Phone Number

At the time of the appointment: Remind the examining practitioner of the Medicaid claims requirement that when submitting the claim for processing, the medical provider must indicate on the claim that the routine medical assessment was provided to a client applying for, or receiving services from one of the HCB DD Medicaid waivers for adults.