

Nebraska Medicaid Managed Care Program Certification of Need for Services

Initial Authorization/Initial Clinical Assessment/POC

Re-Authorization/Plan of Care

Admission Date: _____

*Authorization Start Date _____

*Authorization End Date _____

Date of Request: _____

Managed Care Organization		
<input type="checkbox"/> UHC Phone: _____ Fax: _____	<input type="checkbox"/> Nebraska Total Care Phone: _____ Fax: _____	<input type="checkbox"/> WellCare Phone: _____ Fax: _____
Provider(s) Information		
Provider/Facility Contact Person: _____	Phone #: _____ Fax #: _____	Ordering Physician: NPI#: _____
Facility Information		
Name: _____	Medicaid Provider #: _____	NPI: _____
Member Information		
Name: _____	Date of Birth: _____	Nebraska Medicaid #: _____
Address: _____	Mobile Phone #: _____ Home Phone #: _____	Contact Information: 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:		
<ul style="list-style-type: none"> _____ 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: _____	Date: _____
_____	Evaluating Team Member Signature: _____	Date: _____
_____	Evaluating Team Member Signature: _____	Date: _____
_____	Evaluating Team Member Signature: _____	Date: _____
_____	Parent/Legal Guardian Signature: _____	Date: _____