STATE OF COLORADO

NURSING FACILITY POST ELIGIBILITY TREATMENT OF INCOME (NF PETI) PROGRAM

FACILITY INSTRUCTIONS:

1. Complete one state approved NF PETI request form for each revenue code, i.e. Dental, Health Insurance, Vision, Hearing.
2. Attach the physician's approval of this service, supply or equipment item. Physician's approval is evidenced by either 1) a copy of the physician's order or 2) the physician's signature on the medical necessity statement.
3. Attach a copy of the itemized bill with CPT codes. For hearing aid requests, also attach a copy of a current audiogram.
4. Attach the rendering provider's indication of medical necessity of the requested service or item. This is either 1) signature on the medical necessity statement or 2) a written declaration of medical necessity and signature on the itemized bill.
5. Attach a medical necessity statement signed by the client or the client's responsible party (as defined in Department rules) acknowledging that the requested service or item is desired and the medical necessity and cost involved are known.
6. Copies of this information shall be retained by the facility for at least six (6) years for audit purposes.
7. Submit this request to: **NF PETI PROGRAM, DEPARTMENT OF HEALTH CARE POLICY & FINANCING, 1570 GRANT STREET, DENVER, CO 80203-1818.**

COMPLETE THE FOLLOWING: DATE: _____

Facility Name _____

Facility Address _____

Phone Number _____ Fax Number _____

Contact Person: _____ Email Address _____

CLIENT INFORMATION:

1. Client Last Name _____ First Name _____ Middle Initial _____
2. Client Medicaid ID # _____ Date of Birth _____ Is this client in Hospice? _____Yes _____No
3. Monthly Patient Payment $_____
4. Current Request Amount $_____ Anticipated Number Of Payments _____
5. Year to Date NF PETI Authorized: $_____ Installment Agreement Signed and on file? _____Yes _____No
6. Has NF PETI paid for? Complete only the line related to the requested type of service.

   Denture(s) in the last year? __ Yes or ___ No, in the last 5 years? ___ Yes or ___ No Amount $_____

   Eye Glasses in the last year? ___Yes or ___ No, in the last 2 years? ___ Yes or ___ No Amount $_____

   Hearing Aids in the last year? __ Yes or ___ No, in the last 5 years? ___Yes or ___ No Amount $ _____

   Health Insurance renewal? ___Yes or ___ No

CIRCLE REQUESTED SERVICE: 479 Hearing & Ear 962 Vision & Eye 969 Dental 999 Health Insurance/Other

FOR DEPARTMENT USE ONLY:

Approved Amount: $_____ Amended Amount: **$**_____ Denied Amount: **$**_____

Denial/Amendment Reason: _____

_____

_____

Authorized Signature: _____ Date:_____