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

*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/Otolaryngologist’s Signature  License#  Date

______________________________  __________________  ______________
Dental Provider’s Signature  License#  Date

______________________________  __________________  ______________
Vision Provider’s Signature  License#  Date

I agree to the purchase of the supplies and/or equipment covered by this request. I understand that NF PETI may not cover the entire cost.

______________________________  __________________  ______________
Signature of Client or Responsible Party (required)  Relationship

*Note: an actual signature is required. Verbal consent is not an allowable option.*

COMPLETE NURSING FACILITY PETI CHECKLIST ON PAGE 2
NURSING FACILITY PETI CHECKLIST
Complete 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 of premium amount
☐ Insurance Card – 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 $1000 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)
  (Note: BC HIS is not an acceptable license to perform the audiogram)

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