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/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

1570 Grant Street, Denver, CO 80203-1818 P 303.866.4158 F 303.866.3991
www.colorado.gov/hcpf

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