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.

<table>
<thead>
<tr>
<th>Physician's Signature Required</th>
<th>License#</th>
<th>Date</th>
</tr>
</thead>
</table>

Physician's Print Name

**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.

<table>
<thead>
<tr>
<th>Acupuncturist's Signature</th>
<th>Print Name</th>
<th>License#</th>
<th>Date</th>
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</table>

<table>
<thead>
<tr>
<th>Audiologist's Signature</th>
<th>Print Name</th>
<th>License#</th>
<th>Date</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Dental Provider’s Signature</th>
<th>Print Name</th>
<th>License#</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Vision Provider’s Signature</th>
<th>Print Name</th>
<th>License#</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Signature of Client or Responsible Party</th>
<th>Relationship</th>
<th>Date</th>
</tr>
</thead>
</table>

**Note:** a Verbal consent is **not** an allowable option I agree to the purchase of the supplies and or services covered by this request. I understand the NF PETI PAR may not cover the entire cost and I can be responsible.
NURSING FACILITY PETITION 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 Statement of premium monthly amount
- ☐ Insurance Card Copies 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 $1500 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