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

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.

Acupuncturist's Signature Print Name License# Date

Audiologist's Signature Print Name License# Date

Dental Provider's Signature Print Name License# Date

Vision Provider's Signature Print Name License# Date

Signature of Client or Responsible Party Relationship Date

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.

Contact Information: List contact information of who created this claim.

Name Telephone Number Date

Revised September 2022

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NURSING FACILITY PETI CHECKLIST

Complete the 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)

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
☐ Resident's current eye prescription