



Nebraska Medicaid Managed Care Program Certification of Need for Services

Initial Authorization/Initial Clinical Assessment/POC

Re-Authorization/Plan of Care

Admission Date: _____

*Authorization Start Date _____

*Authorization End Date _____

Date of Request: _____

Managed Care Organization		
<input type="checkbox"/> UnitedHealthcare Community Plan Fax: 1-844-881-4926	<input type="checkbox"/> Nebraska Total Care Fax: 1-866-593-1955	<input type="checkbox"/> WellCare Fax: 1-877-849-5071
Provider(s) Information		
Provider/Facility Contact Person:	Phone #: Fax #:	Ordering Physician: NPI#:
Facility Information		
Name:	Medicaid Provider #:	NPI:
Member Information		
Name:	Date of Birth:	Nebraska Medicaid #:
Address:	Mobile Phone #: Home Phone #:	Contact Information: Relationship: Phone #:
Physician and Evaluation Team Certification of Need for Services:		
<p>I have assessed the client and certify that the client meets the PRTF level of care requirements, according to CMS regulations, including:</p> <ul style="list-style-type: none"> _____ Ambulatory care resources available in the community do not meet the treatment needs of the individual. _____ Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician. _____ The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed. 		
_____ Physician Signature:		Date: _____
_____ Evaluating Team Member Signature:		Date: _____
_____ Evaluating Team Member Signature:		Date: _____
_____ Evaluating Team Member Signature:		Date: _____
_____ Parent/Legal Guardian Signature:		Date: _____