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: ___________

<table>
<tr><td colspan="6" align="center">Managed Care Organization</td></tr>
<tr><td colspan="2" align="center">☐ UnitedHealthcare Community Plan
Fax: 1-844-881-4926</td><td colspan="2" align="center">☐ Nebraska Total Care
Fax: 1-866-593-1955</td><td colspan="2" align="center">☐ WellCare
Fax: 1-877-849-5071</td></tr>
<tr><td colspan="6" align="center">Provider(s) Information</td></tr>
<tr><td colspan="2">Provider/Facility Contact Person:</td><td colspan="2">Phone #:
Fax #:</td><td colspan="2">Ordering Physician:
NPI#:</td></tr>
<tr><td colspan="6" align="center">Facility Information</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Medicaid Provider #:</td><td colspan="2">NPI:</td></tr>
<tr><td colspan="6" align="center">Member Information</td></tr>
<tr><td colspan="2">Name:</td><td colspan="2">Date of Birth:</td><td colspan="2">Nebraska Medicaid #:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">Mobile Phone #:
Home Phone #:</td><td colspan="2">Contact Information:
Relationship:
Phone #:</td></tr>
<tr><td colspan="6" align="center">Physician and Evaluation Team Certification of Need for Services:</td></tr>
<tr><td colspan="6">I have assessed the client and certify that the client meets the PRTF level of care requirements, according to CMS regulations, including:

• _________ 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.</td></tr>
<tr><td colspan="6">____ Physician Signature: _______________________ Date:
____ Evaluating Team Member Signature: __________ Date:
____ Evaluating Team Member Signature: __________ Date:
____ Evaluating Team Member Signature: __________ Date:
____Parent/Legal Guardian Signature:______________Date:</td></tr>
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