Completing a Physician's Certification Form

pennsylvania
DEPARTMENT OF HUMAN SERVICES
INDEPENDENT ENROLLMENT BROKER

Physician's Certification Form

Some patients apply for Home and Community Based Services to get services and support in their home instead of in an institutional setting. If your patient applies, you must complete, sign and submit a Physician Certification Form.

There are four ways to submit the form:

- Electronic signature (recommended)
- Email
- Fax
- Mail

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Need help?

Use this guide to learn more about how to complete a Physician's Certification Form. The guide will help you make sure your form is complete and correct.

If this form is incomplete or incorrect, we will **not** accept it. We will send it back to you and you will have to redo a new form.

If you have questions, call us at **1-877-550-4227**
(TTY: 1-877-824-9346). The call is free.

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Electronic signature (recommended)

Adobe Sign is the fastest and best way to submit a form. It makes sure your form is complete and correct. It gives you tips while you fill out the form and tells you if something is missing or wrong.

To submit the form using your electronic signature:

1. Go to https://paieb.com/PhysiciansCertificationLanding.html
2. Use Adobe Sign to complete, sign and submit the form.

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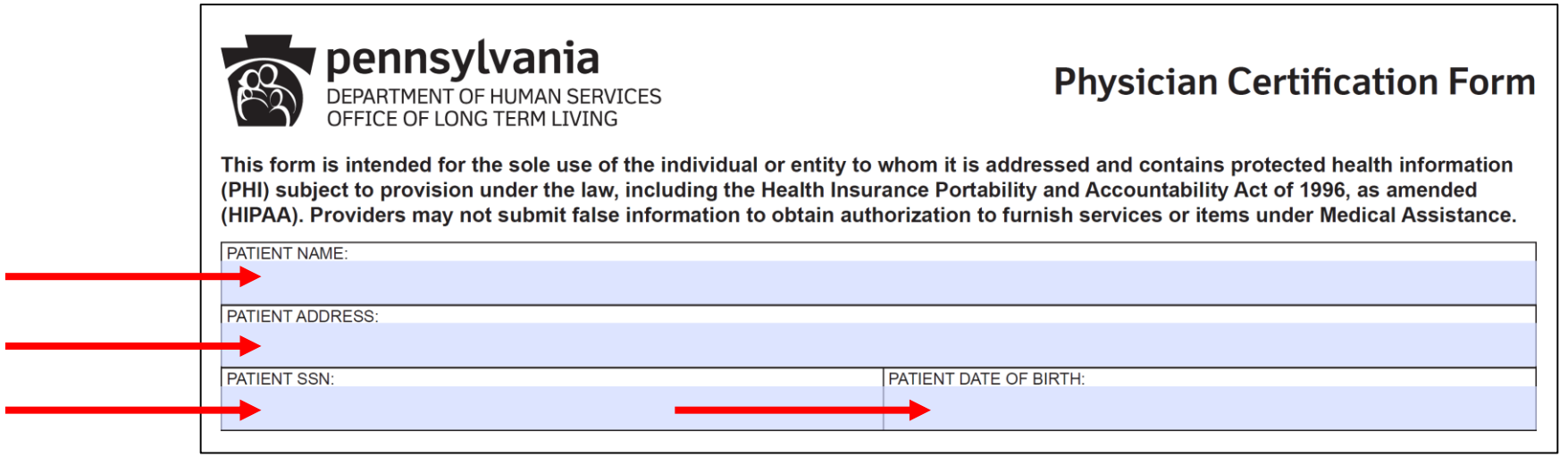
Patient information

Include this patient information:

- Name
- Address
- Social Security number (SSN)
- Date of birth



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OFFICE OF LONG TERM LIVING

Physician Certification Form

This form is intended for the sole use of the individual or entity to whom it is addressed and contains protected health information (PHI) subject to provision under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). Providers may not submit false information to obtain authorization to furnish services or items under Medical Assistance.

PATIENT NAME:	
PATIENT ADDRESS:	
PATIENT SSN:	PATIENT DATE OF BIRTH:

Diagnosis

List **all** of the following:

- All diagnoses related to your patient's need for care
- Any brain injury
- Any developmental disability
- All related ICD 10 codes

DIAGNOSIS

Please list all diagnoses with ICD codes related to patient's need for care. Please ensure that you include diagnoses of brain injury and/ or developmental disability if present.

ICD 10 CODE:	PHYSICIAN DIAGNOSIS:

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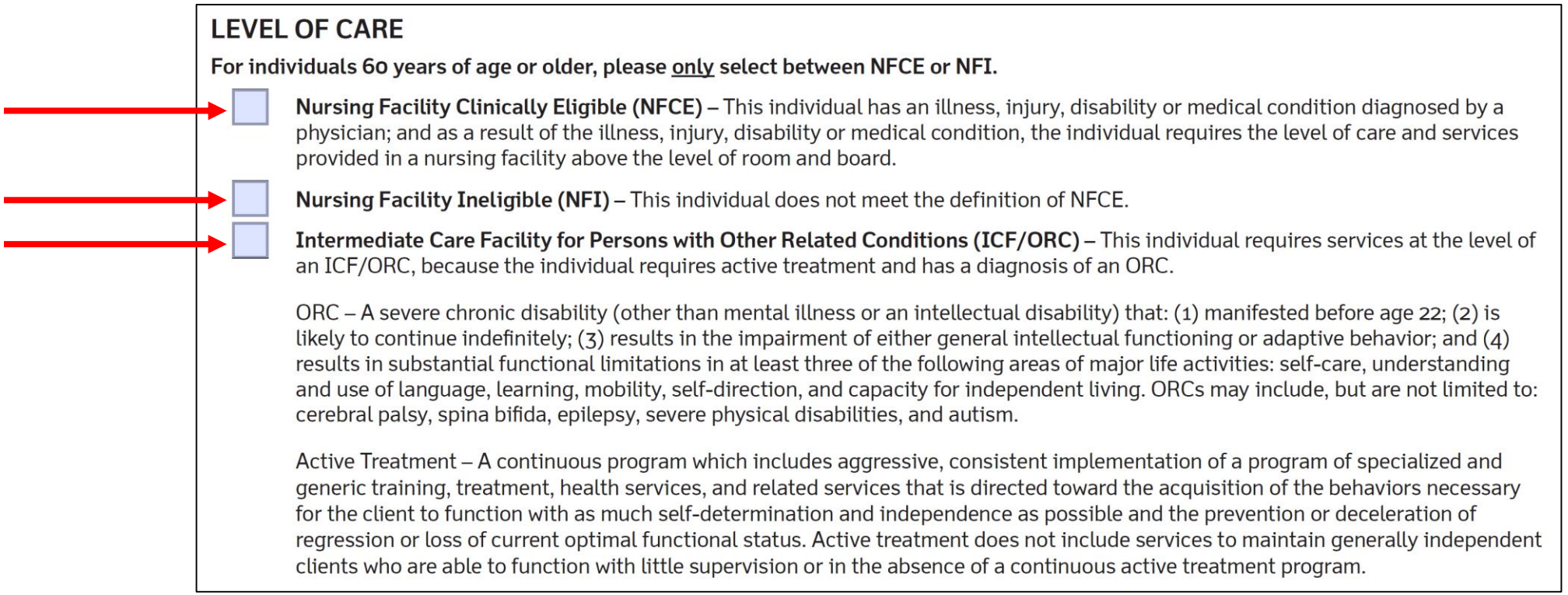
Level of care

Check **one** box.

- For patients age 60 and older, choose NFCE **or** NFI.



LEVEL OF CARE

For individuals 60 years of age or older, please only select between NFCE or NFI.

☐ **Nursing Facility Clinically Eligible (NFCE)** – This individual has an illness, injury, disability or medical condition diagnosed by a physician; and as a result of the illness, injury, disability or medical condition, the individual requires the level of care and services provided in a nursing facility above the level of room and board.

☐ **Nursing Facility Ineligible (NFI)** – This individual does not meet the definition of NFCE.

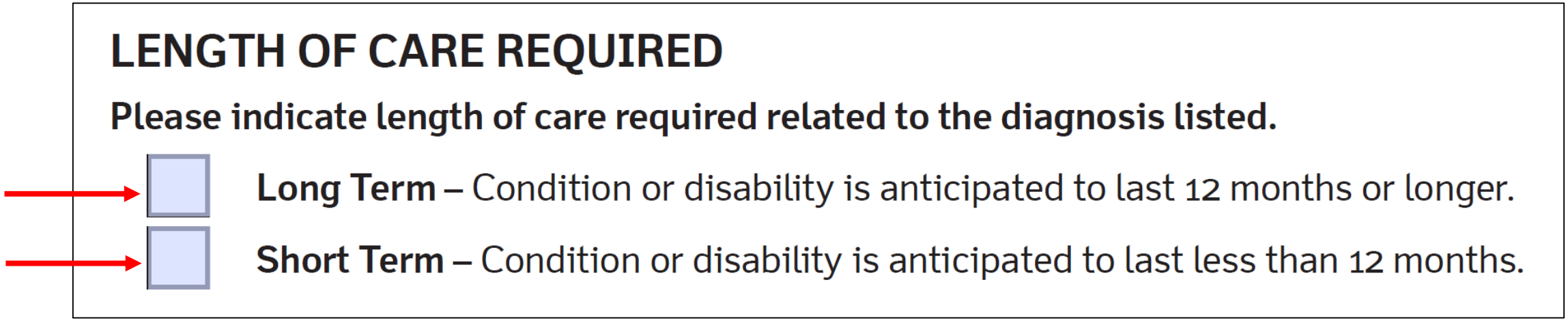
☐ **Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)** – This individual requires services at the level of an ICF/ORC, because the individual requires active treatment and has a diagnosis of an ORC.

ORC – A severe chronic disability (other than mental illness or an intellectual disability) that: (1) manifested before age 22; (2) is likely to continue indefinitely; (3) results in the impairment of either general intellectual functioning or adaptive behavior; and (4) results in substantial functional limitations in at least three of the following areas of major life activities: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. ORCs may include, but are not limited to: cerebral palsy, spina bifida, epilepsy, severe physical disabilities, and autism.

Active Treatment – A continuous program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

Length of care required

Check **one** box.



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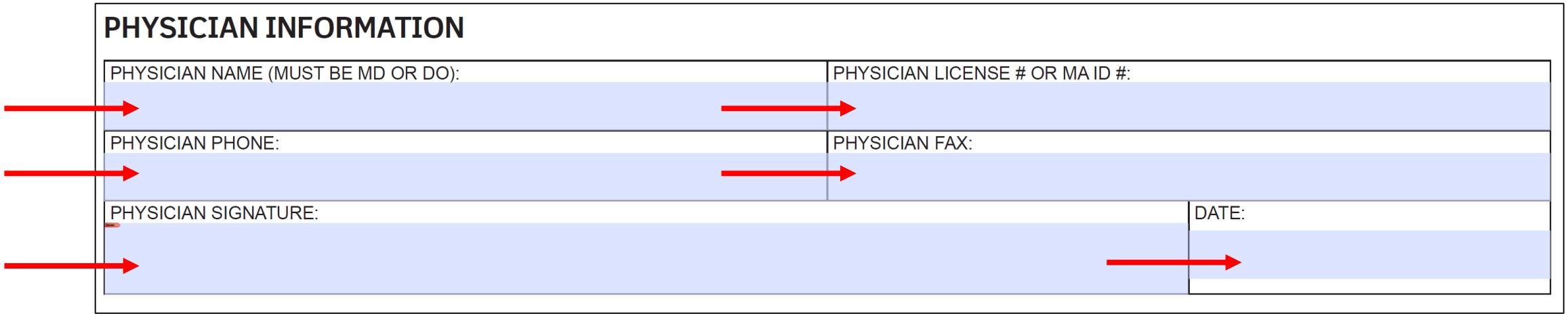
Physician information

Include this physician information:

- Name (**must** be MD or DO)
- License number of attending MD or DO
- Phone number
- Fax number

Reminder: You must sign and date this section.



PHYSICIAN INFORMATION

PHYSICIAN NAME (MUST BE MD OR DO):	PHYSICIAN LICENSE # OR MA ID #:
PHYSICIAN PHONE:	PHYSICIAN FAX:
PHYSICIAN SIGNATURE:	DATE:

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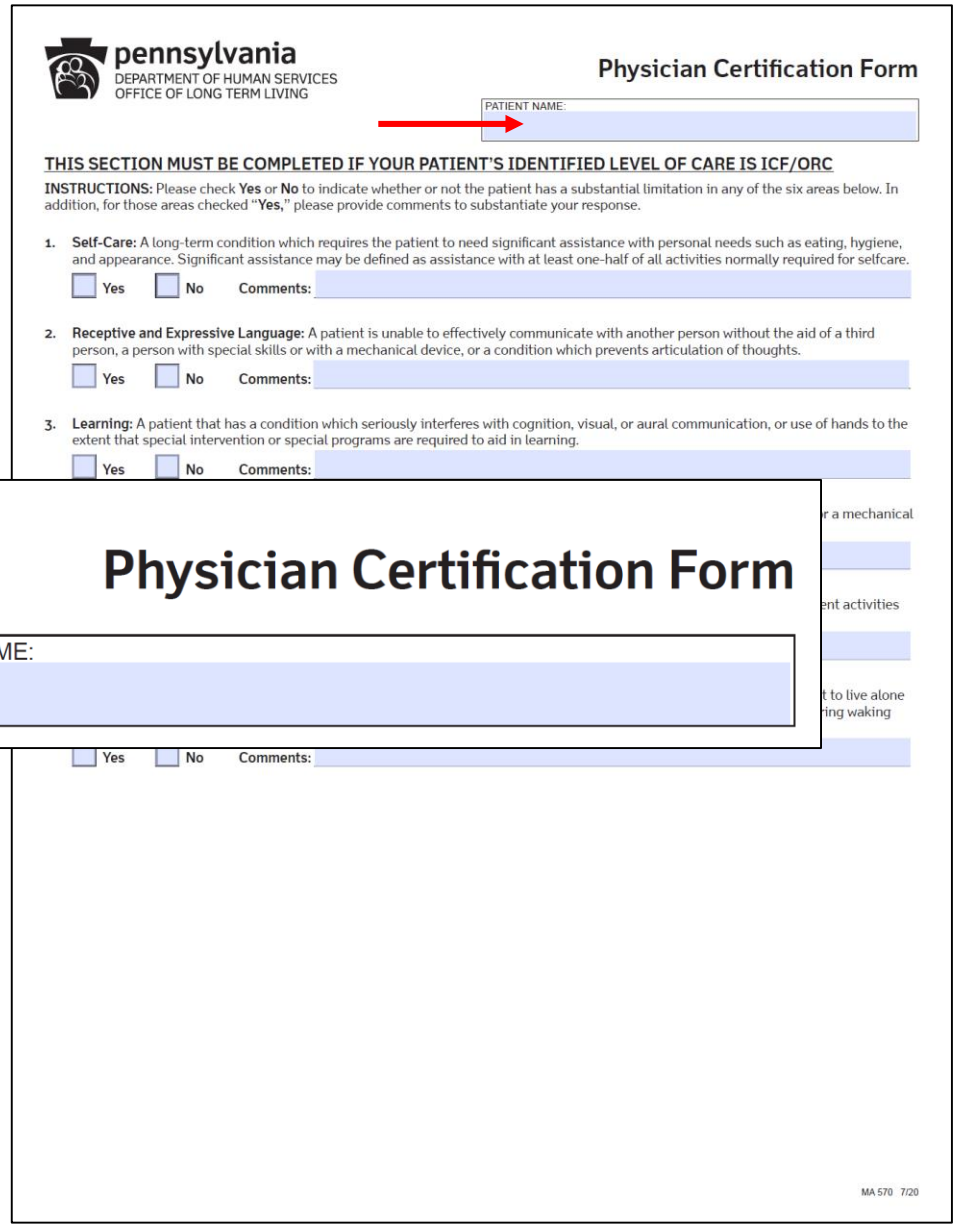
Patient name

At the top right of page 2, remember to re-enter the patient name.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Physician Certification Form

PATIENT NAME:

THIS SECTION MUST BE COMPLETED IF YOUR PATIENT'S IDENTIFIED LEVEL OF CARE IS ICF/ORC

INSTRUCTIONS: Please check **Yes** or **No** to indicate whether or not the patient has a substantial limitation in any of the six areas below. In addition, for those areas checked "**Yes,**" please provide comments to substantiate your response.

1. **Self-Care:** A long-term condition which requires the patient to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance with at least one-half of all activities normally required for selfcare.
   Yes No Comments:
2. **Receptive and Expressive Language:** A patient is unable to effectively communicate with another person without the aid of a third person, a person with special skills or with a mechanical device, or a condition which prevents articulation of thoughts.
   Yes No Comments:
3. **Learning:** A patient that has a condition which seriously interferes with cognition, visual, or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.
   Yes No Comments:

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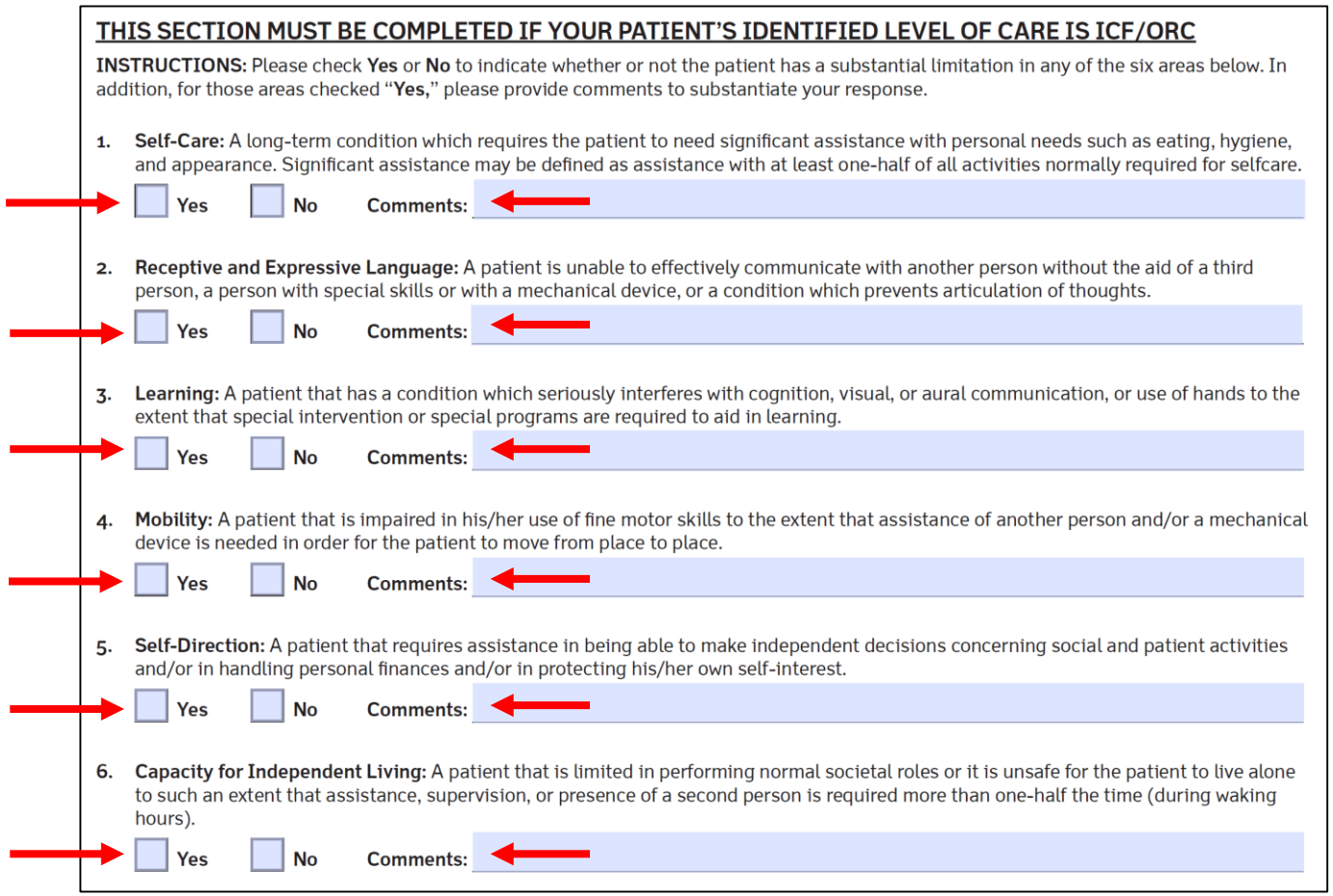
PATIENT NAME:

Patients with ICF/ORC level of care

If your patient's level of care is ICF/ORC, you **must** complete the section on page 2.

- For **every question**, check yes or no.
- For **each question you check yes**, add comments.



THIS SECTION MUST BE COMPLETED IF YOUR PATIENT'S IDENTIFIED LEVEL OF CARE IS ICF/ORC

INSTRUCTIONS: Please check **Yes** or **No** to indicate whether or not the patient has a substantial limitation in any of the six areas below. In addition, for those areas checked "**Yes,**" please provide comments to substantiate your response.

1. **Self-Care:** A long-term condition which requires the patient to need significant assistance with personal needs such as eating, hygiene, and appearance. Significant assistance may be defined as assistance with at least one-half of all activities normally required for selfcare.

☐ Yes ☐ No **Comments:**

2. **Receptive and Expressive Language:** A patient is unable to effectively communicate with another person without the aid of a third person, a person with special skills or with a mechanical device, or a condition which prevents articulation of thoughts.

☐ Yes ☐ No **Comments:**

3. **Learning:** A patient that has a condition which seriously interferes with cognition, visual, or aural communication, or use of hands to the extent that special intervention or special programs are required to aid in learning.

☐ Yes ☐ No **Comments:**

4. **Mobility:** A patient that is impaired in his/her use of fine motor skills to the extent that assistance of another person and/or a mechanical device is needed in order for the patient to move from place to place.

☐ Yes ☐ No **Comments:**

5. **Self-Direction:** A patient that requires assistance in being able to make independent decisions concerning social and patient activities and/or in handling personal finances and/or in protecting his/her own self-interest.

☐ Yes ☐ No **Comments:**

6. **Capacity for Independent Living:** A patient that is limited in performing normal societal roles or it is unsafe for the patient to live alone to such an extent that assistance, supervision, or presence of a second person is required more than one-half the time (during waking hours).

☐ Yes ☐ No **Comments:**

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We’re here to help!

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Pennsylvania Independent Enrollment Broker

- P.O. Box 61560
  Harrisburg, PA 17106
- Fax: 1-888-349-0264
- Website: paieb.com

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