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		
☐ **UnitedHealthcare Community Plan** Fax: 1-844-881-4926	☐ **Nebraska Total Care** Fax: 1-866-593-1955	☐ **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:		
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.**		
_____ **Physician Signature:** _____ **Date:** _____ **Evaluating Team Member Signature:** _____ **Date:** _____ **Evaluating Team Member Signature:** _____ **Date:** _____ **Evaluating Team Member Signature:** _____ **Date:** _____**Parent/Legal Guardian Signature:**_____**Date:**		