Reset Form

CERTIFICATION OF THE NEED FOR INPATIENT PSYCHIATRIC HOSPITAL SERVICES

State Form 44697 (R4 / 5-15) / OMPP 1261A
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF MEDICAID POLICY AND PLANNING

PRIOR AUTHORIZATION NUMBER

Medicare? ☐ Yes ☐ No

COMPLETED BY PROVIDER	COMPLETED BY HOSPITAL PERSONNEL
Medicaid Number	Provider Hospital *(name, address, city, state and ZIP code)*

PATIENT IDENTIFICATION

Name *(First, Last, Middle)*	Gender	Ethnicity	Date of Birth *(mm/dd/yyyy)*

Admitted from:
☐ Own Home ☐ Parent's Home ☐ Other (*designate*)

Date of Admission *(mm/dd/yyyy)*	Time of Admission ☐ AM ☐ PM	Estimated Length of Stay

Psychiatric and Medical Evaluation

Primary Psychiatric Diagnosis:

Secondary Psychiatric Diagnoses:

Medical History:

Summary of present medical findings:

Summary of present psychiatric findings:

Functional Capacity

Can patient take his/her own medication? ☐ Yes ☐ No	Is patient capable of handling his/her own affairs? ☐ Yes ☐ No

Mental Capacity:

Physical Capacity:

Prognoses and Recommendations
Summary of recommendations for treatment and expected prognoses after treatment:

INTERDISCIPLINARY TEAM CERTIFICATION	
Based upon physical, mental and social evaluations, I certify the above named individual requires inpatient psychiatric treatment. Available alternative community resources do not meet the patient's mental health care needs. The prognoses and recommendations identified are verified as existing or beginning on this date. I further attest that an established written plan of care has been implemented and outlined in the patient's medical record in accordance with the requirements of 405 IAC 5-20-4 and 42 CFR 456.170 et seq.	
Signature of Physician Team Member	Date Signed *(mm/dd/yyyy)*

MEDICAID AGENCY DECISION	
☐ APPROVAL ☐ DENIAL COMMENTS:	
Signature of Reviewing Physician	Date Signed (mm/dd/yyyy)