

**MEDICAL NECESSITY STATEMENT PHYSICIAN REFERRALS**

**FOR**

**REHABILITATIVE SERVICES**

Beneficiary’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Diagnosis codes must be based on the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the International *Classification of Diseases (ICD).*]

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Services(s) for the maximum reduction of emotional, behavioral, and functional developmental delays and restoration of the beneficiary to his or her best possible functioning level. This beneficiary meets the Medical Necessity criteria for Rehabilitative Services as evidenced by a Psychiatric diagnosis from the current edition of the DSM or ICD.

**Indicate the specific Rehabilitative Service(s) being recommended on each line below.**

Rehabilitative Service(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rehabilitative Service(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rehabilitative Service(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identify the Beneficiary’s problem areas for Rehabilitative Services listed above. The recommendation must be based on recent clinical information, staffing recommendations, review(s) of treatment history and/ or evaluation(s) made within federal and state standards \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Physician) (Professional Title)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print name signed above) Phone Number)

Signature Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Services must be initiated within 45 calendar days.)

 **Must be handwritten**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of referred LIP Fax # of LIP NPI of referred LIP

**SEND REQUESTS TO:** KePRO

**FAX (855-300-0082), PHONE (855-326-5219) OR VIA WEB PORTAL (http://scdhhs.kepro.com)**

**Note: The Referral/Authorization for Rehabilitative Services form (the KePRO Prior Authorization form) and the MNS must be sent to the provider prior to the provision of services, or at the time the services are rendered.**

Revised: 06/2012