Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MASSHEALTH ADULT DAY HEALTH

Primary Care Provider (PCP) Order Form

This form must be completed in its entirety and signed by the member's primary care provider (PCP) to receive prior authorization (PA) for ADH services.

MassHealth Member and Provider Information	
Member's Name:	
MassHealth ID:	Date of Birth:
Member's Address:	
Member's Telephone Number:	
Adult Day Health Provider:	
ADH Address:	
ADH Telephone Number:	

Prescribing Provider (PCP): Please complete the following information, or indicate that this information and any supporting documentation are attached.

Diagnoses:

_____ _____

_____ _____

_____ _____

Medications: (Please include dosage and amount.)

_____ _____

_____ _____

_____ _____

Known Allergies:

_____ _____

_____ _____

_____ _____

Dietary Needs/Restrictions:

_____ _____

_____ _____

_____ _____

Member's Name: _____ MassHealth ID: _____

Treatments/Rehab Services/Assistance Required with ADLs:

_____ _____

_____ _____

_____ _____

PCP Visit History:

Date of Last Physical Exam: _____ Date of Last Office Visit: _____

Pertinent Findings of Physical Exam (includes vital signs and current weight, cognitive assessment/status, physical capabilities):

_____ _____

_____ _____

_____ _____

Current Rehabilitative Services:

_____ _____

_____ _____

_____ _____

Tuberculosis Screening Results (if warranted by ADH TB Risk Assessment): ☐ **Yes** ☐ **No**

Test Planted Date: _____ **Test Read Date:** _____ ☐ **Positive** ☐ **Negative**

PCP Information
MassHealth requires that services be ordered, referred, or prescribed (ORP). ACA Section 6401(b) requires that 1) the billing provider include the ORP provider's NPI on the claim; and 2) the ORP provider be actively enrolled with MassHealth as a fully participating provider or as a non-billing provider.
Prescribing Provider's Name:
Prescribing Provider's Address:
Prescribing Provider's Telephone:
Prescribing Provider's MassHealth Provider ID/Service Location:
Prescribing Provider's NPI:
Prescribing Provider Attestation
I certify that I am the prescribing provider and recommend this patient for Adult Day Health. I certify that the above on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein. _____ _____ **Prescribing Provider's Signature** **Date** **Credentials**: ☐ **MD** ☐ **PA** ☐ **NP** ☐ **DO** Attach additional narration or documentation as necessary.

Clear form **Print**