



Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid www.mass.gov/masshealth

MASSHEALTH ADULT DAY HEALTH (ADH)

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.

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