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Commonwealth of Massachusetts

Executive Office of Health and Human Services

Office of Medicaid [www.mass.gov/masshealth](http://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**