**Please note. This document has been formatted for use with screen readers.**

# MassHealth Adult Foster Care Primary Care Provider (PCP) Order Form

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

This form must be completed by the adult foster care (AFC) provider and reviewed, verified, and signed by the member’s PCP in order to receive prior authorization (PA).

### Member Information

Member’s Name: Enter Member's Name Here

MassHealth ID: Enter MassHealth ID Here

Member’s Address: Enter Member’s Address Here

Member’s Telephone: Enter Member’s Telephone (XXX) XXX-XXXX Here

Date of Birth: Enter Date of Birth (MM/DD/YYYY) Here

AFC Provider Agency Name: Enter AFC Provider Agency Name Here

AFC Provider Agency Address: Enter AFC Provider Agency Address here

AFC Provider Agency Assessment of Medical Necessity Criteria (130 CMR 408.000, 130 CMR 450.000):

AFC Provider Agency Assessment of Medical Necessity Criteria

## Section I: To be completed by AFC Provider and reviewed/approved by PCP

### Activities of Daily Living

### Please refer to AFC Medical Necessity Guidelines Section II.A.2.a–f for Clinical Eligibility Criteria

[ ]  Bathing

Daily Hands-on (Physical) Assistance Needed? [ ]  Yes [ ]  No

Cueing and Supervision Required During Entire Activity? [ ]  Yes [ ]  No

[ ]  Dressing

Daily Hands-on (Physical) Assistance Needed? [ ]  Yes [ ]  No

Cueing and Supervision Required During Entire Activity? [ ]  Yes [ ]  No

Member Name: Enter Member Name Here MassHealth ID #: Enter MassHealth ID # Here

[ ]  Toileting

Daily Hands-on (Physical) Assistance Needed? [ ]  Yes [ ]  No

Cueing and Supervision Required During Entire Activity? [ ]  Yes [ ]  No

[ ]  Transferring

Daily Hands-on (Physical) Assistance Needed? [ ]  Yes [ ]  No

Cueing and Supervision Required During Entire Activity? [ ]  Yes [ ]  No

[ ]  Mobility (Ambulation)

Daily Hands-on (Physical) Assistance Needed? [ ]  Yes [ ]  No

Cueing and Supervision Required During Entire Activity? [ ]  Yes [ ]  No

[ ]  Eating

Daily Hands-on (Physical) Assistance Needed? [ ]  Yes [ ]  No

Cueing and Supervision Required During Entire Activity? [ ]  Yes [ ]  No

### Behaviors

Wandering: moving with no rational purpose, seemingly oblivious to needs or safety [ ]  Yes [ ]  No

Verbally abusive behavioral symptoms: threatening, screaming, or cursing at others [ ]  Yes [ ]  No

Physically abusive behavioral symptoms: hitting, shoving, or scratching [ ]  Yes [ ]  No

Socially inappropriate or disruptive behavioral symptoms: disruptive sounds, noisiness, screaming, self-abusive acts, disrobing in public, smearing or throwing food or feces, rummaging, repetitive behavior, or causing general disruption [ ]  Yes [ ]  No

Resisting care [ ]  Yes [ ]  No

The Member Diagnosis and Signs and Symptoms below should support the need for AFC services.

Member Diagnosis: Enter Member Diagnosis Here

Member Signs and Symptoms: Enter Member Signs and Symptoms Here

AFC Provider Attestation: I certify that I am the requesting AFC provider. I certify that the clinical eligibility/medical necessity information (per 130 CMR 408.416, 130 CMR 450.204) 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.

AFC Provider’s Signature Enter AFC Provider’s Signature Here Date:

Circle Applicable Credentials: RN, NP

Member Name: Enter Member Name Here MassHealth ID #: Enter Masshealth ID # Here

## Section II: PCP Review and Attestation: Please review Section I information and complete the PCP information and attestation below.

### Ordering Provider (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 nonbilling provider.**

Prescribing Provider’s Name: Enter Prescribing Provider’s Name Here

Prescribing Provider’s Address: Enter Prescribing Provider’s Address Here

Prescribing Provider’s Telephone: Enter Prescribing Provider’s Telephone Here

Prescribing Provider’s MassHealth Provider ID/Service Location:

Enter Prescribing Provider’s MassHealth Provider ID/Service Location Here

Prescribing Provider’s NPI: Enter Prescribing Provider’s NPI Here

### Prescribing Provider Attestation:

I certify that I am the prescribing provider. I certify that the clinical eligibility/medical necessity information (per 130 CMR 408.416 and 130 CMR 450.204) 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: Enter Prescribing Provider’s Signature Here Date:

Circle Applicable Credentials MD, DO, NP, PA

(Form code) AFC-PCP-2-0421