MASSHEALTH MEDICAL NECESSITY REVIEW FORM for
ADDITIONAL DOULA PERINATAL VISITS

THE COMMONWEALTH OF MASSACHUSETTS | EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

All fields in this document must be completed. Submitting an incomplete form may lead to a deferral, which could delay the review process.

Member name	Telephone	Date of birth
Address	MassHealth ID	

Member's managed care plan, if applicable (found in the Eligibility Verification System [EVS])

☐ Member is currently pregnant. Expected date of delivery .....
☐ Member is currently postpartum.

☐ Member is the adoptive parent of an infant under one year of age.

Criteria for medical necessity determination are listed below. Check each condition that applies.

Primary maternal concern (please select one):

- ☐ Physical health (e.g., stroke, eclampsia, ICU admission, etc.)
- ☐ Behavioral health (e.g., anxiety, depression, substance use disorder, etc.)
- ☐ Social risk factors (e.g., housing instability, food insecurity, etc.)
- ☐ Other (please specify):

.....

.....

Primary newborn/infant concern (please select one):

- ☐ Neonatal intensive care unit (NICU) admission
- ☐ Congenital anomalies or disorders
- ☐ Feeding difficulties
- ☐ Neonatal abstinence syndrome
- ☐ Other (please specify):

.....

.....

- ☐ Not applicable

Please detail why it's necessary to request additional doula perinatal visits.

1. For the selected primary concern, please provide a brief statement about the support and/or services that the member is currently receiving to address it. Supports can be healthcare- or community-based. If none, please explain why:

.....

2. Have you reviewed our **Resource Guide**, and did you then try to connect the member with their managed care plan for additional supports that they may qualify for? ☐ Yes ☐ No
If no, please explain why:

.....

3. Check the box for any other healthcare- and community-based services/supports that the member qualifies for and is currently using (or if the member has declined, describe why):

.....

Women, Infants, & Children Nutrition Program (WIC)	☐ Yes	☐ Declined	☐ Not applicable
Care coordination services through the member's managed care plan (e.g., care management, community partner program, housing or nutrition supports, etc.)	☐ Yes	☐ Declined	☐ Not applicable
Community-based support group (e.g., through Postpartum Support International)	☐ Yes	☐ Declined	☐ Not applicable
Clinical support for mental health and/or substance use disorder (e.g., therapist, peer recovery coach, etc.)	☐ Yes	☐ Declined	☐ Not applicable
Clinical support from an obstetric and/or primary care provider (e.g., OB/GYN, midwife, PCP, etc.)	☐ Yes	☐ Declined	☐ Not applicable
Home visiting program (e.g., Welcome Family, Early Intervention, etc.)	☐ Yes	☐ Declined	☐ Not applicable

Other (please describe): .....

4. Plan of Care

Start date	End date	
Number of units	Number of hours per day	Number of days per week

What are the goals of the care plan ?

If this is a subsequent (second or beyond) request for additional perinatal services for this member, please detail the member's progress in achieving goals since you began providing care for this member.

Do you anticipate requesting additional perinatal doula visits for this member in the future? ☐ Yes ☐ No
If yes, please explain why:

Rendering provider name	Date PA requested
Rendering provider telephone	Rendering provider email

Save As Clear form Print