Oregon Medicaid Managed Care Program
Certification of Need for Services

☐ Initial Authorization/Initial Clinical Assessment/POC ☐ Re-Authorization/Plan of Care

Admission Date: _____ *Authorization Start Date_____ *Authorization End Date_____

Date of Request: _____

Managed Care Organization		
☐ **Trillium Community Health Plan** **Fax: 1-833-505-1300**		
Provider(s) Information		
Provider/Facility Contact Person:	Phone #: Fax #:	Ordering Physician: NPI#:
Facility Information		
Name:	Medicaid Provider #:	NPI:
Member Information		
Name:	Date of Birth:	Oregon Medicaid #:
Address:	Mobile Phone #: Home Phone #:	Contact Information: Relationship: Phone #:

Physician and Evaluation Team Certification of Need for Services:

I have assessed the client and certify that the client meets the PRTF level of care requirements, according to CMS regulations, including:

- _____ **Ambulatory care resources available in the community do not meet the treatment needs of the individual.**
- _____ **Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
- _____ **The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.**

_____ **Physician Signature** _____ **Date**
_____ **Evaluating Team Member Signature** _____ **Date**
_____ **Evaluating Team Member Signature** _____ **Date**
_____ **Evaluating Team Member Signature** _____ **Date**
_____ **Parent/Legal Guardian Signature** _____ **Date**