



Certificate of Medical Necessity for Environmental Modification

Use this form as your cover page. Fax to Utilization Management Waiver Prior Authorization 844-399-0479.
(Please print or type clearly – accuracy is important)

Section A						
1. Member Name (Last) (First) (Initial)			2. Case Manager Name			
3. Medicaid SID #		4. Date of Birth		5. Service Plan Dates Covered by Request		
				From		To
Month	Day	Year	Month	Day	Year	
6. Name of Item Requested:						
7. Type of Review Being Requested: <input type="checkbox"/> Initial <input type="checkbox"/> Continued Stay Review (CSR) <input type="checkbox"/> Revised form <input type="checkbox"/> Re-review				<i>Remember to attach all documentation.</i> 8. Documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No (see Section D) 9. Number of pages including this one:		

Section B Answer ALL Questions 1 through 13 for Environmental Modification	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have other funding sources been tried? Outline in Section C. <input type="checkbox"/> Community services fund <input type="checkbox"/> Family <input type="checkbox"/> Other <input type="checkbox"/> Charitable organizations <input type="checkbox"/> State plan durable medical equipment
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is this device covered by other funding sources? Outline in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Is this an existing structure? If yes, provide detailed information in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. If this is an existing structure, can it be repaired? Describe in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Is this modification for the sole benefit of the member? Describe benefit to member in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Are any of the contractors related to the member? If yes, provide relationship in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Will this modification increase or maintain the independence of the member? If yes, outline in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Does this modification address a health, safety, or welfare issue for this member? Outline in Section C.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Does the service plan identify the need for requested modification?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Will the case manager obtain assurance of liability and workers compensation coverage from contractor?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. To the best of my knowledge, the contractors submitted for review are reputable?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Is there documentation that a mental health professional has recommended this modification? Outline details in Section C.
	13. Does the member or member's family <input type="checkbox"/> Own <input type="checkbox"/> Live in provider-owned home <input type="checkbox"/> Rent <input type="checkbox"/> Live in HUD housing

Section C Narrative Description Justification Request	
Provide specific information and use additional sheet if necessary. Provide the cost of items that are \$50 or under.	
IMPORTANT NOTE: In evaluating requests for prior authorization, the need for treatment or services will be considered from the standpoint of medical necessity only. An approval of this request does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish eligibility at the time of service.	<div style="text-align: center; border-bottom: 1px solid black; margin-bottom: 5px;">Requesting Case Manager</div> <div style="display: flex; justify-content: space-between;"> Signature of TCM/CM/SW Date </div>

Section D Include ALL of the Following Documentation

- Comprehensive functional assessment
- Case manager or social worker service plan
- Three independent itemized estimates (if over \$50)
- Documented description of the item that includes the medical, remedial, or safety benefit to the member
- Mental health professional recommendation
- Denial for state plan durable medical equipment, if applicable
- If existing item, need repair versus replacement cost estimate