Certificate of Need for Psychiatric Hospitalization or Psychiatric Medical Institution for Children (PMIC)

Member information	
Patient name:	DOB:
Legal guardian:	
Medicaid/health plan number:	Is the member currently a Medicaid recipient? ☐ Yes ☐ No

Check the below as applicable (all three are required for a Certificate of Need):

☐ Ambulatory resources available in the community have been tried and are inadequate to meet the treatment needs of the member at this time.

☐ Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist or physician.

☐ Services are expected to improve the patient's condition within a reasonable period of time or prevent regression to the extent that services will no longer be needed.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Signatures		
Physician name	**Signature**	**Date**
Position/facility/credentials:		
Position/facility/credentials:		
Position/facility/credentials:		
Position/facility/credentials:		
Position/facility/credentials:		
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