PA Independent Enrollment Broker

Dear Physician:

Your patient has applied for Home and Community Based Waiver Services. The enclosed Physician's Certification Form is a required part of your patient's waiver application. Please complete, sign and return the form within **5 days** of receipt.

On the form, please indicate your patient's level of care using the definitions below. The form **replaces** the MA-51 for this level of care certification.

If you have questions, call us at **1-877-550-4227**.

Thank you,
PA Independent Enrollment Broker

Level of Care Definitions

Nursing Facility Clinically Eligible (NFCE)

A person:

- Has an illness, injury, disability or medical condition diagnosed by a physician, **and**
- As a result of that diagnosed illness, injury, disability or medical condition, requires care and services above the level of room and board, **and**
- Is Nursing Facility Clinically Eligible (NFCE) as certified by a physician, **and**
- Needs either skilled nursing or rehabilitation services or health-related care and services that may not be as complex as skilled nursing or rehabilitation services, but are needed and regularly given in a planned health care and management program and were previously only available through institutional facilities.

Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)

A person:

- Has a diagnosis of an Other Related Condition (ORC)—a severe, chronic disability—other than a mental illness or an intellectual disability—that manifested before age 22, is likely to continue indefinitely, results in the impairment of either general intellectual functioning or adaptive behavior, and results in substantial functional limitations in at least three of these areas: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living, **and**
- Requires active treatment—a continuous program that aggressively, consistently gives specialized and generic training, treatment, health services and related services; that focuses on the client acquiring behaviors necessary to function with as much self-determination and independence as possible; and that aims to prevent or slow regression or loss of current optimal functional status.


P.O. Box 61077
Harrisburg, PA 17106


Call us toll free at
1-877-550-4227


Send a fax to
1-888-349-0264


Email us at
paieb@maximus.com

PA Independent Enrollment Broker

Physician's Certification Form

Name: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

Diagnoses: Please include diagnosis of Traumatic Brain Injury (TBI) and/or Developmental Disability, if present.

Physical Diagnoses
ICD 10 Codes

Length of Care Required

- ☐ Long-term (over 180 days)
- ☐ Short-term (180 days or less)

Level of Care Required: Please refer to enclosed cover letter for Level of Care Definitions as needed.

- ☐ Nursing Facility Clinically Eligible (NFCE)
- ☐ Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)
- ☐ None of the above, please explain:

  _____

Physician Information

Physician Name (must be MD or DO)	
Physician License # or **MAID #**	
Physician Phone	**Physician Fax**
Physician Signature	**Date**

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