



STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAID PROGRAM

Certificate of Medical Necessity for Community Health Worker (CHW)
Units

Recipient Name: _____ DOB: _____

Recipient Medicaid ID Number: _____

Name of Requesting Provider: _____ NPI: _____

Please answer the following:

A. This is a request for exceeding:

a. ___ Daily Limit of 2 Hours. Units requested: _____

b. ___ Monthly limit of 12 hours. Units requested: _____

B. Please attach a brief description of services that CHW will provide.

C. Please attach any clinical or other documents that will support the request.

Provider Signature: Date Signed: _____

Print Provider Name: _____

Provider Address: _____

Provider telephone number: _____

Please send form via: fax, secure email or postal mail.

FAX: 401-784-3892

Email: RIXIX-PA@gainwelltechnologies.com

Postal address: PO Box 2010 Warwick, RI 02887

Proof of medical necessity will be reviewed monthly, if approved.