



RI PREVENTIVE SERVICES PROGRAM MEDICAL NECESSITY EVALUATION REQUEST

ALL INFORMATION MUST BE LEGIBLE, OR THE REQUEST CANNOT BE PROCESSED

Type of Request (please check one): Initial Reevaluation Emergency/Facility Discharge

Please submit Initial and Emergency PCMNERS to Department of Human Services (DHS): DHS.ClinicalTeam@dhs.ri.gov

APPLICANT/MEMBER INFORMATION			
First Name:	Middle Name:	Last Name:	Suffix:
Date of Birth:		Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SSN:	Medicaid #:	Medicare #	
Member's Physical Address (Indicate Facility's name and contact info if the request is for Emergency/Facility Discharge):			
Member's Mailing Address:			
County of Residence (or Facility's County)		Member's Phone # (or Facility's Phone #):	
Signature of Applicant/Member	X	Date:	
<input type="checkbox"/> Check if Applicant/Member is his/her own Legal Representative			
LEGAL REPRESENTATIVE, GUARDIAN, OR CONTACT INFORMATION (REQUIRED IF APPLICANT/MEMBER HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES OR IS UNDER THE AGE OF 18- ALL ARE ENCOURAGED TO LIST A CONTACT PERSON TO ASSIST			
Name:		Phone #:	
Mailing Address:			
Relationship to Applicant/Member	<input type="checkbox"/> Guardian <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Contact/Other (describe): _____		
Signature of Legal Representative (not needed if contact person)	X	Date:	
REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/member).			
Name (MD, DO, PA, Nurse Practitioner)		Phone #	Fax #
Mailing Address (include city, state, zip):			
Patient Diagnoses			
Reason for Referral:			
Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please specify
Is the patient terminal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Physician (MD, DO PA or Nurse Practitioner; original required)	X	Date (valid for 60 days):	