Certification of Need: Medicaid Inpatient Psychiatric Services Under Age 21

Recipient Name: ____________________  Hospital: ____________________

Medicaid ID #: ____________________  Provider #: ____________________

Date of Birth: ____________________  Admission Date: ________________

Type of Certification: (check 1 item)  Medicaid Eligibility Status: (check 1 item)
  □ Pre-admission/elective  □ Medicaid eligible on admission
  □ Emergency admission  □ Pending Medicaid on admission
  □ No evidence of Medicaid on admission  □ Applied for Medicaid during stay
  □ Applied for Medicaid after discharge

At the time of admission, the interdisciplinary team certifies the following:

1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.

2. Proper treatment of the recipient’s condition requires services on an inpatient basis under the
direction of a physician.

3. The inpatient services can reasonably be expected to improve the recipient’s condition or prevent
further regression so that services will no longer be needed.

Physician Team Member  Print Name/Title  Date (Mo/Day/Yr)

Other Team Member Signature  Print Name/Title  Date (Mo/Day/Yr)

Please submit to the appropriate UR Vendor when completed.

The Durham Center (Durham County): 919-328-6011
Eastpointe LME (Duplin, Lenoir, Sampson, and Wayne Counties): 910-298-7184
ValueOptions (All Other Counties): 877-339-8763