Dear Physician:

Beginning in January 2019, Pennsylvania is improving the way we provide services through a new program known as Community HealthChoices (CHC) to:

- people enrolled in both Medicare and Medicaid,
- people enrolled in Medicaid waivers for physical disabilities and older adults, and
- Medicaid-eligible people who live in a nursing home.

CHC is Pennsylvania's mandatory managed care program for eligible individuals — serving more people in communities, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life.

Your patient is currently receiving services through the Pennsylvania's OBRA Waiver. We need your assistance in completing the attached physician certification form as part of a level of care assessment to determine whether your patient is eligible for CHC.

Please complete and return the physician certification form no later than 10 calendar days after receipt to the person's Service Coordinator (SC) at:

Fax Number	( ) -
Contact Name	
Agency Name	
Mailing Address	

Thank you very much for your time and attention to this matter. If you have any questions, you may contact the SC at _____.

Respectfully,

Kevin Hancock
Acting Deputy Secretary

Level of Care Definitions:

- **Nursing Facility Clinically Eligible (NFCE)** – The individual 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, the individual requires care and services above the level of room and board; and a physician certifies that the individual is NFCE; and the care and services are either a) skilled nursing or rehabilitation services as specified by the Medicare Program in 42 CFR §§ 409.31(a), 409.31(b)(1) and (3), and 409.32 through 409.35; or b) health-related care and services that may not be as inherently complex as skilled nursing or rehabilitation services but which are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities.
- **Nursing Facility Ineligible (NFI)** – Individuals who do not meet the definition of NFCE are considered NFI.
- **Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)** – Has a diagnosis of 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 an 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 of 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.

Physician's Certification Form

Patient Information

<Name>
<Address>
<City>, PA <ZIP>
Social Security Number: <SSN>
Date of Birth: <DOB>

➡ **Please complete this form and send it to [Insert SCE Name]**
Fax: [Insert Fax Number]
Mail: [Insert Address Line 1]
[Insert Address Line 2]
[Insert Address Line 3]

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**