

NURSING FACILITY PAE CERTIFICATION FORM

APPLICANT'S NAME: _____

APPLICANT'S SSN: _____

REQUIRED ATTACHMENTS (When a PAE is required, the following attachments **must** be included)

- ✓ A recent History and Physical (completed within 365 days of the PAE Request Date or date of Physician Certification below, whichever is earlier) OR other recent medical records supporting the applicant's functional and/or skilled nursing or rehabilitative needs; and
- ✓ If skilled nursing and/or rehabilitative services are being requested, a separate Physician's Order for such service(s) must be attached and supporting documentation for reimbursement based on the need for such service(s).

PHYSICIAN CERTIFICATION OF LEVEL OF CARE AND PHYSICIAN ORDER FOR NF SERVICES

Must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.

I certify that the applicant **requires the level of care provided in a nursing facility** and that the requested long-term care services are medically necessary for this applicant. **Medically necessary** care in a nursing facility must be expected to **improve or ameliorate** the individual's physical or mental condition, to **prevent deterioration** in health status, or to **delay progression** of a disease or disability, and such care must be ordered and supervised by a physician on an ongoing basis. I further certify that **I am ordering nursing facility services on an ongoing basis**. I understand that this information will be used to determine the applicant's eligibility for long-term care services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.

DIAGNOSES relevant to applicant's functional and/or skilled nursing needs:

Must be SIGNED by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist

Signature and Credentials: _____ Signature Date: _____

Printed name of signature listed above: _____

**Please note: If skilled and/or rehabilitative service(s) are being requested, a separate MD Order for such service(s) must be attached to the PAE.*

COMPLETE THE SECTION BELOW ONLY IF THE PAE MUST BE RECERTIFIED

CERTIFICATION UPDATE: I certify that the applicant's medical condition on the recertified PAE is consistent with that described in the initial certification (above) and that Nursing Facility services are medically necessary for the applicant.

Must be SIGNED by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist

Recert PAE Request Date	Signature and Credentials	Date of Signature