MAP-570
(Rev. 5/90)

MEDICAID CERTIFICATION OF NEED
FOR
INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21

Recipient Name _____ Facility _____

MAID # _____ Date of Birth _____

Admission Date _____

ICD-9-CM DIAGNOSIS CODES 1. _____ 3. _____

2. _____ 4. _____

The interdisciplinary team certifies the following:

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

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

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

_____ _____

Signature of Physician Team Member Date

_____ _____

Signature of Other Team Member Date

COMPLETE ON ALL EMERGENCY ADMISSIONS AND MEDICAID APPLICANTS AFTER ADMISSION