DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11047 (02/09)

STATE OF WISCONSIN
DHS 107.13, Wis. Admin. Code

WISCONSIN MEDICAID

CERTIFICATION OF NEED FOR ELECTIVE / URGENT PSYCHIATRIC/SUBSTANCE ABUSE ADMISSIONS TO HOSPITAL INSTITUTIONS FOR MENTAL DISEASE FOR MEMBERS UNDER AGE 21

ForwardHealth requires information to enable the programs to certify providers and to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information shall include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of payment for the services.

Completion and retention of this form is required under s. 7000 of the Hospital Inpatient State Plan. Failure to complete and retain this form may result in denial of payment for the services.

INSTRUCTIONS

1. Type or print clearly.
2. All requested information must be provided, including physician and team member credentials. Providers may use their own version of this form as long as it includes all the same information.
3. Persons completing this form must be members of an independent team that:
   - Do not have an employment or consultant relationship with the admitting facility.
   - Includes a physician.
   - Have competence in diagnosis and treatment of mental illness, preferably in child psychiatry.
   - Have knowledge of the member's situation.
4. The physician and team members signing this form must sign their full names and write their credentials; initials may be used for the first and/or middle name only. A signature stamp or computer-generated signature is acceptable as long as the hospital institution for mental disease (IMD) has written policies and procedures covering these signatures. Verbal orders and/or telephone orders are acceptable, but they must be co-signed by the physician giving the order and the date of the co-signature of the physician must be written beside the signature. The hospital IMD written policies and procedures must state the allowed time by which a verbal order or telephone order must be co-signed by the physician. The signature must be dated within this time frame for it to be accepted.
5. If the signature and completion dates indicated on the form differ, the Certification of Need (CON) form will be presumed to have been completed on the latest date indicated on the form.
6. Retain the completed form in the member's medical record.
7. For more information about CON procedures, contact Provider Services at (800) 947-9627.

SECTION I — MEMBER INFORMATION

Name — Member	Member ID (10 digits)	Date of Birth (MM/DD/CCYY)

SECTION II — FACILITY INFORMATION

Name — Admitting Facility	Provider Number
Address — Admitting Facility (Street, City, State, and ZIP Code)	Date of Admission (MM/DD/CCYY)

We hereby certify the following:

- Ambulatory care resources available in the community do not meet the treatment needs of this member.
- Proper treatment of the member's psychiatric condition requires services on an inpatient basis under the direction of a physician.
- The services can reasonably be expected to improve the member's condition or prevent further regression so that the services will no longer be needed.

Name — Physician (Print)

SIGNATURE — Physician	Credentials	Date Signed
SIGNATURE — Other Team Member	Credentials	Date Signed
SIGNATURE — Other Team Member	Credentials	Date Signed

Date of CON Form Completion (MM/DD/CCYY)

Reset Form