PAE CERTIFICATION FORM

APPLICANT'S NAME ____
SSN: ______________________________ **PAE REQUEST DATE:** ____________________

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;
- ✓ Current Physician's Orders for NF service and/or level of NF reimbursement requested (as applicable); and
- ✓ Supporting documentation for reimbursement of skilled nursing and/or rehabilitative services or for a higher Cost Neutrality Cap (as applicable) based on the need for such services.

CERTIFICATION OF ASSESSMENT *May be completed by a Physician, Nurse Practitioner, Physician Assistant, Registered or Licensed Nurse, or Licensed Social Worker.*
I certify that the level of care information provided in this PAE is accurate. I understand that this information will be used to determine the applicant's eligibility and/or reimbursement 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.
Assessor Name: ________________________ Credentials: ________________ Date: ____________

PHYSICIAN CERTIFICATION of LEVEL OF CARE (NF Services Only)
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 a 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 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**. Original signature, NPI, Medicaid ID, and date must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist with the date the level of care is certified.**

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

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Printed Name of LOC Certifier: ________________________NPI: __________ Medicaid ID: __________

Signature and Credentials: ______________________________ Signature Date: ________________

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 and that Nursing Facility services (or an equivalent level of HCBS) are medically necessary for the applicant.

Recert PAE Request Date	Signature of Physician (for NF)	Date of Signature