Letter of Medical Necessity for Certified Nursing Assistant (CNA) or Home Health Aide (T1021)

This form must be completed by an MD or DO enrolled with UnitedHealthcare Community Plan of Florida. The practitioner (MD/DO) is required to sign this form **no more than** 30 calendar days prior to the date of request for services. In addition, for initial services for home health care under T1021, the provider must have examined the member within the last 30 days. For recertification of home health services under T1021, the provider must have examined the member within the last 180 days.

Instructions: Please submit this form using the Prior Authorization and Notification tool on Link

1. Member Information

Member Name _____ DOB _____

UHC Subscriber ID _____

2. Diagnosis and Treatment

Member's diagnosis that requires home health care _____

Home health services needed _____

Frequency and duration of the needed services _____

Minimum skill level required to deliver services (CNA or Home Health Aide) _____

3. Provider Attestation

☐ **Yes**, I hereby attest the following:

-This individual has been examined by me within the past 30 days (for initial requests) or 180 days (for recertification requests) ***and***

-This individual has an impairment which substantially limits one or more of the person's life activities (a major life activity includes but is not limited to caring for one's self, performing manual tasks, walking, working) ***and***

-This individual is unable to leave home without the assistance of another person ***or*** leaving home is medically contraindicated and would increase the medical risk for exacerbation or deterioration of the individual's condition.

☐ **No**, I am unable to attest that this individual has been examined within the past 30 days (for initial approval) or 180 days (for recertification) ***and*** has a medical condition and impairment as described above.

MD/DO signature _____

MD/DO printed name _____

Date _____

Address _____

_____

Phone _____

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