EPSDT Medicaid Template

Patient Name_____ Medicaid # _____ Date of Birth: _____

Date of last exam: _____ Primary Care Provider: _____Medicare Provider #_____

Medical Diagnosis: _____ Developmental Diagnosis: _____

Other Diagnoses: _____

PER EPSDT MANDATES**,** I am writing to request (insert home care, specific rehabilitation service, DME or assistive device etc.) approval for the above patient.

The request is medically necessary for the following reasons:
*(Choose one or more)***.**

____ It will, or is reasonably expected to, **prevent** the onset of an illness, condition or disability. (Provide details).
____ It will, or is reasonably expected to, **reduce** or **ameliorate** the physical, mental, or developmental effects of an injury, illness, or disability. (Provide details).
____ It will assist the individual to **achieve** or **maintain** maximum functional capacity in performing daily activities**, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.** (Provide details).

If prescribing services in the home, include:
_____number of hours per week for Personal Care Aide; Private Duty Nursing; Skilled Nursing. *Services are prescribed* for_____(Duration).

DOCUMENT WHY CARE NEEDS EXCEED WHAT FAMILY CAN DO ALONE. (Particularly when health care services are requested in the home, cite Federal EPSDT law, 42 USD 1396d(a)(7) which mandates states to cover all medically necessary services within the broad scope of Medicaid for those 0-21.) This includes medications, parenteral or enteral feedings, and skill acquisition in ADLs, bathing/personal hygiene, toileting, and transfers.

Please contact me if you require additional information from my records.

_____
(Signature)

Be sure the PCP or Medical Home Provider refers to your prescription on the standard EPSDT form.