PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)

This section provides detailed instructions for completion of the ***Form DMA-6 (A)***. Before payment can be made, a ***Form DMA-6 (A)*** must be completed by the ***Primary Care Physician (PCP) and the parent or legal representative*** and signed by the PCP. The ***Form DMA-6 (A)*** is considered valid only if it is signed by the ***Primary Care Physician*** and dated.

Section A - Identifying Information

It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

Item 1: **Applicant's Name and Address**
Enter the complete name and address of the applicant including the city and zip code.

The caseworker in the Department of Family and Children Services (DFCS) will complete the mailing address and county of the originating application.

Item 2: **Medicaid Number**
Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways:

a. If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444;

b. If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or

c. If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S.

The entire number must be placed on the form correctly. In exceptional instances, it may be necessary to contact the caseworker in the DFCS office for the Medicaid number.

Item 3: Social Security Number
Enter the applicant's nine-digit Social Security number.

Item 4 & 4A: Sex, Age and Date of birth
Enter the applicant's sex, age, and date of birth.

Item 5: Primary Care Physician
Enter the entire name of the Primary Care Physician (PCP).

Item 6: Telephone Number
Enter the telephone number including area code of the applicant's parent or the legal representative.

Item 7: Does the parent or legal representative think the applicant should be institutionalized?
Please check the appropriate box.

Item 8: Does the child attend school?
Please check the appropriate box if the member attends school.

Item 9: Date of Medicaid Application
Enter the date the family made application for Medicaid services.

Fields below Item 9:
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, please indicate the name of the caregiver.

Read the statement below the name(s) of the caregiver(s) and then;
Item 10: Signature
The parent or legal representative for the applicant should sign the DMA-6 (A).

Item 11: Date
Please include the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation

Item 12: History (attach additional sheet(s) if needed)
Describe the applicant's medical history (Hospital records may be attached).

Item 13: Diagnosis (Add attachment(s) for additional diagnoses)
Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.

Item 14: Medications (Add attachment(s) for additional medication(s)
The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.

Item 15: Diagnostic and Treatment Procedures
Any diagnostic or treatment procedures and frequencies should be indicated.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative, and other health care services the applicant has received or currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization
List any dates the applicant may be hospitalized in the near future for services.

Item 18: Level of Care Recommended
Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded.

Item 19: Type of Recommendation
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Enter a check in the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Enter a check in the box corresponding to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.

Item 24: Physician's Name and Address
Print the admitting or attending physician's name and address in the spaces provided.

Item 25: Certification Statement of the Physician and Signature
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable.

Item 26: Date signed by the physician
Enter the date the physician signs the form.

Item 27: Physician's Licensure Number
Enter the Georgia license number for the attending or admitting physician.

Item 28: Physician's Telephone Number
Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed (Check Appropriate box only)

Licensed personnel involved in the care of the applicant should complete Section C of this form.

Item 29: Nutrition
Check the appropriate box(es) regarding the nutritional needs of the applicant.

Item 30: Bowel
Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant.

Item 31: Cardiopulmonary Status
Check the appropriate box(es) to indicate the cardiopulmonary status of the applicant.

Item 32: Mobility
Check the appropriate box(es) to indicate the mobility of the applicant.

Item 33: Behavioral Status
Check all appropriate box(es) to indicate the applicant's mental and behavioral status.

Item 34: Integument System
Check the appropriate box(es) to indicate the integument system of the applicant.

Item 35: Urogenital
Check the appropriate box(es) for the urogenital functioning of the applicant.

Item 36: Surgery
Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.

Item 37: Therapy/Visits
Check the appropriate box to indicate the amount of therapy visits the applicant receives.

Item 38: Neurological Status
Check the appropriate box (es) regarding the neurological status of the applicant.

Item 39: Other Therapy Visits
If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs.

Item 40: Remarks
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.

Item 41: Pre-admission Certification Number
Indicate the pre-admission certification number (if applicable).

Item 42: Date Signed
Enter the date this section of the form is completed.

Item 43: **Print Name of MD or RN**
The individual completing Section C should print their name and sign the DMA-6(A).

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.