

Effective date of prescription: ____/____/____

Section I (Sections I, II, III, and IV must be completed by the PERS provider.)

Member's name		MassHealth ID number	
Address		Telephone number ()	
Date of birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight
ICD code	Diagnosis		

Section II

Prescribing provider's name	Telephone number ()
Address	
NPI	Fax number ()

Section III

Supplier's name	Telephone number ()
Address	
NPI	Fax number ()

Section IV

HCPCS Code	HCPCS Code
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Section V (Sections V and VI must be completed by the member's prescribing physician, nurse practitioner, or prescribing physician's or nurse practitioner's staff.)

▶ Length of need: _____

Medical justification for requested item(s)

All questions must be answered "**yes**" to qualify for a PERS.

- Does the member have a medical condition that causes significant functional limitations or incapacitation that will prevent the member from using other methods of summoning assistance in an emergency? yes no
- Does the member have a functioning land-line phone that can accommodate a PERS? yes no
- Does the member live alone or is routinely alone for extended periods of time such that the member's safety would be compromised without the availability of a PERS unit in the home? . . . yes no
- Is the member able to independently use the PERS to summon help? yes no
- Does the member understand when and how to appropriately use the PERS? yes no
- Is the member at risk of moving to a more-restrictive supervised setting, OR is the member at risk for falls or other medical complications that may result in an emergency situation? yes no

Section VI

Prescribing Provider's Attestation and Signature/Date

I certify that I am the prescribing provider identified in Section II of this form. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge, and I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature/credentials _____ (Signature and date stamps are not acceptable.) _____ Date _____

This completed form must be maintained in the member's record.