HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

DEPARTMENTAL MEMORANDUM
MAD-MR: 18-14
DATE: 9/7/2018

TO: **MEDICAL ASSISTANCE DIVISION**

FROM: **NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISION**

THROUGH: **SHARI ROANHORSE-AGUILAR, BUREAU CHIEF, EXEMPT SERVICES AND PROGRAMS BUREAU**

BY: **LINDA GILLET, BRAIN INJURY PROGRAM / ESPB**

SUBJECT: **BRAIN INJURY SERVICES FUND (BISF) TREATMENT VERIFICATION FORM, MAD 772 ISSUED AUGUST 2018**

GENERAL INFORMATION

The MAD 772 is provided by the contracted Service Coordination Agency (SCA) of the Brain Injury Services Fund (BISF) to a Program participant's medical provider for the purpose of confirming that the provider is treating the participant for brain injury or symptoms related to their brain injury. This confirmation is necessary in order for BISF Crisis Interim Services to cover copayments under the provider's care. Upon completion of the form and its return to the SCA, it is forwarded to the BISF's contracted provider of Crisis Interim Services, for coverage of physician copayments.

FILING INSTRUCTIONS

Please make the following replacements in the Medical Assistance Forms Manual:

INSERT MAD 772 Issued August 2018

Please address any questions concerning these guidelines to Lindab.gillet@state.nm.us or call (505) 827-7218.

Attachment: MAD 772 Issued August 2018

HUMAN SERVICES DEPARTMENT

NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM
Medical Assistance Division

TREATMENT VERIFICATION FORM – CRISIS INTERIM SERVICES

FAX TO: Goodwill Industries of New Mexico • 505-884-3157
For Questions: Goodwill Industries of New Mexico • 505-881-6401 (Brain Injury Program)

Dear Attending Physician / Medical Provider,

Your patient, _____ DOB _____ may be eligible to receive assistance from the New Mexico Brain Injury Service's Fund (BISF) Program to cover insurance copayments related to your services. Coverage by the BISF for physician copays requires verification that your patient is being treated for brain injury or symptoms related to brain injury. The BISF Program defines Brain Injury as traumatic or other acquired brain injury, in accordance with approved program ICD-10 Codes. Please complete this form if confirming that you are providing treatment related to your patient's brain injury.

Treatment Verification

I am the Attending Physician treating the patient named below for traumatic or other acquired brain injury and related symptoms.

Name of Patient with Brain Injury: _____

Patient's DOB: _____

_____
Printed Name of Physician, Physician Assistant, or Certified Nurse Practitioner

_____
Address of Physician, Physician Assistant, or Certified Nurse Practitioner

_____
Phone Number of Physician, Physician Assistant, or Certified Nurse Practitioner

_____ _____
Signature of Physician, Physician Assistant, or Certified Nurse Practitioner Date

Please note: This form will automatically expire one year from the date signed. In order to ensure continuity of services beyond an approved year, a new Treatment Verification may be needed in anticipation of the patient's expiration of BISF Program services.

MAD 772 Issued August 2018

HUMAN SERVICES DEPARTMENT

NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM

TREATMENT VERIFICATION FORM - CRISIS INTERIM SERVICES

Form Instructions

PURPOSE: The MAD 772 is a is to be completed by a participant's medical provider for the purpose of confirming that the provider is treating the participant for brain injury or symptoms related to their brain injury. This confirmation is necessary in order for Crisis Interim Services to cover copayments under the provider's care. The top portion is to be completed by the contracted Service Coordination Agency (SCA) of the Brain Injury Services Fund (BISF) Program; it introduces the Program and explains the purpose of the form. The portion of the form inside the box is to be completed by the participant's attending Medical Doctor/Physician, Physician's Assistant, or Certified Nurse Practitioner.

INSTRUCTIONS:

The Service Coordinator (SC) will complete the top portion of the MAD 772 by entering the program participant's name and date of birth (DOB).

The portion of the MAD 772 inside the box is to be completed by the participant's attending Medical Doctor/Physician, Physician's Assistant, or Certified Nurse Practitioner. The licensed Medical Professional will:

1) Enter the name of their patient
2) Enter the patient's Date of Birth
3) Enter their printed name, address and telephone number.
4) Sign in ink and date. The BISF Program cannot accept an electronic signature.
5) Fax the form to the number provided for the SCA at the top of the form.

ROUTING:

The SCA will complete the top of the MAD 772 and send it to the Attending Physician's office. Following its completion by a licensed medical professional, the Physician's office will fax page 1 of the form to the office of the SCA. The SCA will submit the form as part of any service extension beyond one year to the HSD BISF Program Manager. As authorized, the SCA will submit the MAD 772 and any related referral documentation to the contracted Crisis Interim Services Fiscal Intermediary Agency (CIA-FIA). The MAD 772 will be retained by the SCA and CIS-FIA as part of the participant's file.

FORM RETENTION:

Permanent