Alzheimer's Disease and Dementia Diagnosis Verification

This form is intended for patients who have a diagnosis of Alzheimer's disease and/or Dementia and are seeking personal care and/or consumer directed personal assistance services or to enroll in a Managed Long Term Care (MLTC) plan through Medicaid.

Failure to complete and present this form to the assessor at the time of the patient's Community Health Assessment (CHA) may impact the patient's eligibility to receive personal care and/or consumer directed personal assistance services or to join a MLTC plan.

SECTION 1: PATIENT IDENTIFYING INFORMATION

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Medicaid CIN or Social Security Number:** _____

SECTION 2: DIAGNOSIS INFORMATION

Alzheimer's disease: ☐ Yes ☐ No **Dementia:** ☐ Yes ☐ No

ICD-10 Diagnosis Codes for Above Diagnoses (Do not leave blank)**:**

SECTION 3: DIAGNOSING PROVIDER INFORMATION (MUST BE A MD OR DO)

Last Name: _____ **First Name:** _____

Telephone Number: _____ **NPI:** _____

Profession (MD, DO)**:** _____ **License Number:** _____ **State of Licensure:** _____

SECTION 4: PROVIDER COMPLETING FORM (MUST BE A MD, DO, NP, OR PA)

☐ Same as diagnosing provider

Last Name: _____ **First Name:** _____

Telephone Number: _____ **NPI:** _____

Profession (MD, DO)**:** _____ **License Number:** _____ **State of Licensure:** _____

SECTION 5: PROVIDER ATTESTATION

By signing this form, I attest that, to the best of my knowledge, information and belief, the patient identified in Section 1 has been diagnosed with Alzheimer's disease or Dementia as outlined in Section 2 by the diagnosing provider listed in Section 3, and as documented in the patient's medical history and health records. I understand that this verification form is subject to the New York State Department of Health regulations, Parts 515, 516, 517, and 518 of Title 18 NYCRR, which permit the Department to impose monetary penalties on, or sanction and recover overpayments from, providers or prescribers of medical care, services or supplies when medical care, services or supplies are provided or ordered that are unnecessary, improper or exceed the patient's documented medical condition.

Provider Signature: _____ **Date:** _____

Provider Name (Print)**:** _____

INSTRUCTIONS

Complete all items. Incomplete or missing information may impact the patient's eligibility.

Section 1: Patient's Identifying Information

- **Last Name**. Enter the patient's last name.
- **First Name**. Enter the patient's first name.
- **Date of Birth**. Enter the patient's date of birth.
- **Medicaid CIN or Social Security Number**. Enter the patient's Medicaid CIN, found on the patient's Medicaid Assistance ID card, or their social security number.

Section 2: Diagnosis Information

Check the applicable box(es) and provide the Alzheimer's disease or Dementia ICD-10 diagnosis code(s) for the patient identified in Section 1. Do not leave this section blank.

Section 3: Diagnosis Provider Information

Enter information for the provider that diagnosed the patient identified in Section 1 as having Alzheimer's disease or Dementia. The diagnosing provider must be a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).
Do not leave this section blank.

Section 4: Provider Completing Form

If the provider completing the form is the same as the provider in Section 3, check "Same as diagnosing provider".

If the provider completing the form is not the same as the provider in Section 3, enter information for the provider completing the form. The provider completing the form must be a licensed healthcare professional (Doctor of Medicine, Doctor of Osteopathy, Nurse Practitioner, or Physician Assistant) that can attest the patient identified in Section 1 has been diagnosed with Alzheimer's disease or Dementia by a Licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Section 5: Provider Attestation

The signature of the provider completing this form.

Return completed, signed form to the patient or the patient's representative.