Instructions on how to fill out an MA51 can be found on the back of the MA51 form itself or by going to https://www.dhs.pa.gov/providers/Providers/Documents/NHT%20Providers/MA%2051.pdf

What makes an MA51 Valid and Complete?

- Wording must be legible
- For the Medical Information sections 2-20C, physicians should complete as much as they know. If any area says to see notes or see a list, that information must be attached for the Medical Director to review.
- Sections 7 and 8 must be an MD or DO licensed physician. CRNPS are not able to sign.
- Section 20C should match the above physician's information, and the date of signature must be within the year.
- Section 10 should not say verbal permission. A signature must be provided.

If any of the above MA51 information needs to be added or corrected, you should follow up with the provider and request the necessary changes. Please do not accept whiteout on the form for corrections. Please see our MDR Guidance form on our website for more ways to check if the Ma51 is acceptable.

If you receive paperwork from a Nursing Home requesting a FED, only enter the FED request into PIA if the MA51 is completed in its entirety and has valid physician information and a valid signature. If it is not valid or complete, wait to complete the FED once the MA51 is corrected and sent back.

If submitting for a medical director review, the AAA cannot sign the MA51 until the Medical Director Review provides an outcome. Once the medical director provides an outcome, the AAA may sign and complete sections 21A-22.

License Number

Staff should always ensure that a physician's license number is valid before accepting the physician form. To check if a physician's license number is valid, please do the following:

- Go to https://www.dos.pa.gov/ProfessionalLicensing/VerifyaProfessional/Pages/default.aspx
- Click Verify a License on the right
- Under Verify a License on the left, click Person Search

- Plug in the name or license number provided on the form and hit search.
- At the bottom, under Person Details, you will see if a result comes up. If it does, check the following columns to see if they are an MD or DO and if their license is still active to practice: Name, License Type, and Active Status.

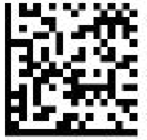
NPI Numbers

If you are provided with an NPI number, you should ask for a corrected form with the license number provided.

How to check if an NPI number has a valid license:

- Go to any NPI Lookup site or go to https://npiregistry.cms.hhs.gov/search
- Type in the NPI number provided
- Check that it matches the name of the physician provided.

INSTRUCTIONS FOR COMPLETING MA-51 MEDICAL EVALUATION



NOTE: THE MA-51 IS VALID AS LONG AS IT REFLECTS THE CURRENT CONDITIONS FOR THE APPLICANT

At the top of the page, mark if this is a new or updated MA-51.

Must be MD or DO license number

Questions 1-7 are self-explanatory.

8. **Physician License Number.** Enter the physician license number, not the Medical Assistance number.

9. **Evaluation At.** Enter 1-5 to describe where evaluation took place. If 5 is used, specify where evaluation was completed.

10. **Signature.** Applicant should sign if able. If unable, legal guardian or responsible party may sign.

11. **Essential Vital Signs.** Self-explanatory.

12. **Medical Summary.** Include any medical information you feel is important for determination of level of care. **Please list patient's known allergies in this section.**

13. **Vacating of building.** How much assistance does the patient require to vacate the building?

14. **Medication Administration.** Is the patient capable of being trained to self-administer medications?

If listing "see attached" then attach a medication list.

15. **Diagnostic Codes and Diagnoses.** ICD diagnostic codes should be put in the blocks, then written by name in the space next to the block. List diagnoses starting with primary, then secondary, and finally tertiary.

16. **Professional and Technical Care Needs.** Indicate care needed. Examples of "other" include mental health and case management.

17. **Physician Orders.** Orders should meet needs indicated in box 16. Medications should have diagnoses to support their use.

18. **Prognosis.** Indicate patient's prognosis based on current medical condition.

19. **Rehabilitation Potential.** Indicate based on current condition. Should be consistent with box 18.

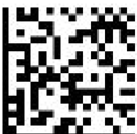
20A. **Physician's Recommendation.** Physician must recommend patient's level of care. If the box for "other" is checked, write in level of care. In order to provide assistance to a physician in the level of care recommendation, the following definitional guidelines should be considered:

Nursing Facility Clinically Eligible (NFCE)	Personal Care Home	ICF/ID Care	ICF/ORC Care	Inpatient Psychiatric Care
Requires health-related care and services because the physical condition necessitates care and services that can be provided in the community with Home and Community Based Services or in a Nursing Facility.	Provides Personal Care services such as meals, housekeeping, & ADL assistance as needed to residents who live on their own in a residential facility.	Provides health-related care to ID individuals. More care than custodial care but less than in a NF.	Provides health-related care to ORC individuals. More care than custodial care but less than in a NF.	Provides inpatient psychiatric services for the diagnoses and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

20B. **Complete only if Consumer is NFCE and will be served in a Nursing Facility.** Check whether the patient will be eventually discharged from facility based on current prognosis. If yes, check expected length of stay.

20C. The physician must sign and date the MA-51. A licensed physician must sign the MA-51. It may not be signed by a "physician in training" (a Medical Doctor in Training [MT] or an Osteopathic Doctor in Training [OT]).

Questions 21 and 22 are completed by Aging Well, the appropriate Department of Human Services program office, or the Department's designee. These questions are used by the Department to certify the individual's medical eligibility for services.



MEDICAL EVALUATION

☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE

5. AGE	6. SEX	7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

Must be DO or MD licensed number and must be legible and must have a date

9. EVALUATION AT (Description and code)
- 01 Hospital
- 02 NF
- 03 Personal Care/Dom Care
- 04 Own House/Apartment
- 05 Other (Specify) ____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT ____ DATE ____

Must be signed and have a date. Please do not write verbal approval here.

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING
☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

	PRIMARY (Principal)
	SECONDARY
	TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) ____

17. PHYSICIAN ORDERS
- Medications ____
- Treatment ____
- Rehabilitative and Restorative Services ____
- Therapies ____
- Diet ____
- Activities ____
- Social Services ____
- Special Procedures for Health and Safety or to Meet Objectives ____

If an area states "see list" or "see notes," you must attach the notes they are referring to for the medical director to review.

18. PROGNOSIS - CHECK ✓ ONLY ONE
☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE
☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A **PHYSICIAN'S RECOMMENDATION** To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

- ☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
- ☐ Personal Care Home Services provided in a Personal Care Home
- ☐ ICF/ID Care Services to be provided at home or in an Intermediate care facility for the intellectually disabled
- ☐ ICF/ORC Care Services to be provided at home or in an Intermediate care facility for consumers with ORCs
- ☐ Inpatient Psychiatric Care
- ☐ Other (Please Specify) ____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**

ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) ____ TELEPHONE ____ PHYSICIAN SIGNATURE ____ DATE ____

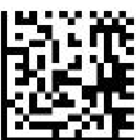
MD or DO licensed physician's signature only. Date must be dated and within a year.

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21 **MEDICALLY ELIGIBLE** ☐ Yes ☐ No

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE ____ DATE ____



ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE