



HUMAN SERVICES  
DEPARTMENT

Michelle Lujan Grisham, Governor  
David R. Scrase, M.D., Secretary Designate  
Nicole Comeaux, J.D., M.P.H., Director

DEPARTMENTAL MEMORANDUM

MAD-MR: 19-15

DATE: November 14, 2019

TO: MEDICAL ASSISTANCE DIVISION

FROM: <sup>VLAGMNC</sup> NICOLE COMEAUX, DIRECTOR, MEDICAL ASSISTANCE DIVISION

THROUGH: <sup>AS</sup> SHARI ROANHORSE-AGUILAR, BUREAU CHIEF, EXEMPT SERVICES AND PROGRAMS BUREAU (ESPB)

BY: LINDA GILLET, BRAIN INJURY PROGRAM / ESPB <sup>AG</sup>

SUBJECT: MAD 772 REVISED SEPTEMBER 2019, BRAIN INJURY SERVICES FUND (BISF) TREATMENT VERIFICATION FORM

**GENERAL INFORMATION**

The MAD 772 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 BISF HCBS to cover copayments under the provider's care. The form was revised as follows:

- Form (page 1):
  - Removed Goodwill Industries of NM; added Care Network and Los Amigos with check boxes and fax numbers;
  - Added direction to contact HSD with any questions; and
- Instructions (page 2):
  - Directed medical professionals to fax the form to the agency checked at the top of the form.

**FILING INSTRUCTIONS**

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

DELETE MAD 772 Revised August 2018  
INSERT MAD 772 Revised September 2019

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

Attachment: MAD 772 Revised September 2019



**NEW MEXICO BRAIN INJURY SERVICES FUND PROGRAM**  
Medical Assistance Division

**TREATMENT VERIFICATION FORM –**  
**BISF HOME AND COMMUNITY BASED SERVICES**

**NOTE TO PHYSICIAN'S OFFICE: FAX TO THE SERVICE COORDINATION AGENCY CHECKED BELOW:**

Care Network; FAX: 888-838-7086

Los Amigos; FAX: 505-474-2804

For Questions: Call the HSD Brain Injury Program Manager at 505-827-7218

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 this date, a new Treatment Verification may be needed in anticipation of the patient's expiration of BISF Program services.

**NEW MEXICO BRAIN INJURY SERVICES FUND (BISF) PROGRAM  
TREATMENT VERIFICATION FORM –  
BISF HOME AND COMMUNITY BASED SERVICES (HCBS)**

**Form Instructions**

**PURPOSE:** The MAD 772 allows a participant’s medical provider to confirm 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 HCBS 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 notifies the medical provider where to fax the completed form, provides information about the BISF 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 checking the name of their agency and 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 Agency checked at the top of the page.

**ROUTING:**

The SCA will send the form to the Attending Physician’s office. Following its completion by a licensed medical professional, the Physician’s office will fax the form to the office of the SCA, checked at the top of the page. 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 BISF HCBS Fiscal Intermediary Agency (FIA). The MAD 772 will be retained by the SCA and BISF HCBS FIA as part of the participant’s file.

**FORM RETENTION:**

Permanent