



Private Duty Nursing/Attendant Nursing Care

Prior Authorization Request Form

Phone Number: (855) 322-4076

Fax Number: (866) 4 4 0 -9791

MEMBER INFORMATION			
Plan:	<input type="checkbox"/> Molina Medicaid (If Molina is secondary, please include a copy of the denial from primary insurance)		
Member Name:		DOB:	/ /
Member ID#:		Phone:	() -
Service Type:	<input type="checkbox"/> Elective/Routine <input type="checkbox"/> Expedited/Urgent		
REFERRAL/SERVICE TYPE REQUESTED			
Diagnosis Code & Description:			
CPT/HCPC Code & Description:			
62 DOS SPAN ONLY For continuation requests, the start date is always the day after the last authorization ends		DOS From:	/ /
		to	/ /
PROVIDER INFORMATION			
Requesting Provider Name:		NPI#:	
		TIN#:	
Servicing Provider or Facility:		NPI#:	
		TIN#:	
Contact at Requesting Provider's Office:			
Phone Number:	() \	Fax Number:	() \
CLINICAL DOCUMENTATION TO SUPPORT NEED FOR PRIVATE DUTY NURSING (PDN)			
Signed and dated physician order for PDN [Please submit: Home Health Certification and Plan of Care]		<input type="checkbox"/> Submitted	
Current history and physical (recent hospital admissions/discharge summaries)	<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted	
Current treatment plan and treatment records	<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted	
Current nursing care plan – Most recent notes (2 weeks)	<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted	
Recent daily nursing notes	<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted	
Emergency medical plan	<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted	
60-DAY SUMMARY/including changes	<input type="checkbox"/> Submitted	<input type="checkbox"/> Not Submitted	
Plan and need for more than one agency to supply care at a time? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If YES, please describe: _____			

CLINICAL PRESENTATION (check all that apply)

Frequency of assessments (to include vital signs, interventions to support patient care, health status assessment, etc.):

- Once per 8-hour shift
- 2-3 times per 8-hour shift
- Hourly or more often

Behavioral health, cognition, developmental monitoring:

- Non-verbal, infrequent speech, or difficult to understand
- Self-abusive behavior, risk of self-harm, and intervention required
- Sleep disturbance and patient awake more than 3 hours per night
- Combative, confused, or disoriented behavior that impacts self-management; patient obese
- Combative, confused, or disoriented behavior that impacts self-management

Respiratory:

- BiPAP/CPAP management
 - More than 8 hours per day
 - Less than 8 hours per day
- Nebulizer therapy
 - More frequent than every 4 hours
 - Every 4-24 hours
 - Less frequent than daily, but at least once every 7 days
- Chest Physiotherapy – percussion, high-frequency chest wall oscillation vest, cough assist device, etc.
 - More than once per hour
 - Every 1-4 hours
 - Less than every 4 hours, but at least daily
- Oxygen management
 - Oxygen humidification, tracheal, no ventilator
 - Oxygen needed at least weekly, based on pulse oximetry
- Suctioning
 - Tracheal suctioning at least once every 2 hours
 - Tracheal suctioning daily, but less than every 2 hours
 - Nasal or oral suctioning daily
- Tracheostomy management
 - Tracheostomy management with complications (skin breakdown, replacement needed)
 - Tracheostomy management, no complications
- Ventilator management
 - Continuous ventilator use
 - Ventilator use for 12 or more hours per day
 - Ventilator use for 7-12 hours per day
 - Ventilator use for less than 7 hours per day
 - Interventions in place for active weaning
 - Ventilator weaning achieved; requires ongoing post-weaning monitoring and management
 - Ventilator on standby, respiratory assistance, or used at night for less than 1 hour

Skilled Nursing Needs:

- Blood draw
 - _____ Central line _____ Peripheral line
 - _____ More than twice per week _____ Less than twice per week
- Infusion therapy
 - Blood or blood product
 - Chemotherapy infusion
 - Central line access and management
 - Pain medication infusion
- Intravenous Infusion (IV antibiotics, etc.), including infusion administration and monitoring for infusion reactions
 - Infusions more than every 4 hours
 - Infusions less than every 4 hours
- Non-infusion medication
 - Insulin administration
 - Non-insulin medication injectable administration
 - Medication administration at least every 2 hours, requiring clinical monitoring
- Activity of Daily Living (ADL)/Therapy support
 - _____ Bedbound _____ Wheelchair user _____ Ambulatory
 - Total/partial lift, weight 55-125 pounds
 - Total/partial lift, weight greater than 125 pounds
 - ADL support needed more than 4 hours per day to maximize patient's independence
 - Body cast management
 - Cast or brace management
 - Splinting management, including removal and replacement, at least every 8 hours
 - Communication deficit; nurse to support therapy plan
 - Range of motion exercises at least every 8 hours
 - Physical therapy program at least 3 hours per day; occupational therapy program at least 4 hours per day
- Nutrition management
 - Enteral nutrition with complications, requires administration of feeding, residual check, adjustment or placement of tube, and assessment or management of complications
 - Enteral nutrition without complications
 - Gastrostomy tube care, uncomplicated
 - Nasogastric tube care, uncomplicated
 - Partial parenteral nutrition with central line care
 - Total parenteral nutrition with central line care
- Skin and wound care management
 - Burn care
 - Ostomy care, at least once per day
 - Postsurgical care, within 45 days of surgery
 - Stage 1 or 2 wound management, at least once per day
 - Stage 3 or 4 wound management, at least once per day
 - Stage 3 or 4 wound management at least once per day, and multiple wound sites
 - Prescribed topical medication application at least every 4 hours
 - Wound vacuum management

- Seizure control that requires nursing intervention/management
 - Seizures lasting less than 3 minutes, at least 4 times per week
 - Seizures lasting 3-5 minutes, at least 4 times per week
 - Seizures lasting 3-5 minutes, 1 to 4 times per day
 - Seizures lasting 3-5 minutes, more than 5 times per day
 - Seizures lasting more than 5 minutes, or clustered seizures, or seizure activity without regaining consciousness, at least 4 times per week
 - Seizures lasting more than 5 minutes, or clustered seizures, or seizure activity without regaining consciousness, one time or more per day, requiring rectal medication
 - Seizures lasting more than 5 minutes, or clustered seizures, or seizure activity without regaining consciousness, one time or more per day, requiring IM or IV medication

ADDITIONAL INFORMATION

List: