delaware first health

Certificate of Medical Necessity for
Private Duty Nursing and Home Health Aide
Fax: 833-967-0502

PLEASE COMPLETE ALL THE SECTIONS ON THIS FORM

Date ____/_____/_____

Member Name_____

Delaware First Health Member ID# _____Member's Date of Birth ____ /____ /____

Parent / Guardian / Caregiver Name: _____Phone:_____

Diagnoses_____

Type of Request:

Initial Request____ Annual Review_____ Change in Medical Condition/Needs_____ Other

(Explain):_____

Level of care requested:

Private Duty Skilled Nurse (PDN) ____ Unskilled Home Health Aide (HHA) ____

Indicate the number of hours/day needed for: Sleep _____ Work _____ School _____

Other (Explain):_____

Hours requested for each day and/or night of the week:_____

_____

_____

***For the following questions, please attach additional documentation if the space provided is insufficient** Past Medical History includes: [**include all relevant history including hospitalizations**].

_____

_____

_____

_____

_____

_____

_____

Current medications include: [**provide current medication list with route, frequency and dosage**]. Please attach a list if needed.

_____
_____
_____
_____
_____

Provide a narrative explaining skilled nursing needs (medical interventions that must be performed by a nurse) and/or unskilled medical needs (requires assistance with activities of daily living) that the nurse or home health aide would be rendering during the hours that are being requested:_____
_____
_____
_____
_____
_____
_____
_____

SUPPORTING CLINICAL INFORMATION

Enteral Feeding: Yes_____ No_____

Bolus Feeds: Yes_____ No_____ Frequency: _____

Continuous Feeds: Yes_____ No_____ PO Feeds: Yes _____ No _____

IV Catheter: Yes_____ No_____ Type: (e.g., PICC, Broviac, Peripheral) Frequency of use:_____

TPN: Yes_____ No _____ Frequency: _____ Duration: _____

Tracheostomy or other Artificial Airway YES _____ NO_____ Ventilator YES ____ NO ____

Ventilator Settings _____

Hours per day on ventilator _____ which hours_____ Continuous_____ Sleep Only____
Most recent recorded oxygen saturation level _____ Date_____

Respiratory Issues(s) Oxygen: Yes_____ No_____

Continuous: _____ Intermittent: _____ PRN: _____

Pulse Ox: Yes_____ No _____

Seizures: Yes_____ No_____

Average number of seizures per day: _____ Average Duration: _____

Interventions (VNS, Diastat, Oxygen, etc.)_____

Date of member's last seizure & interventions utilized: _____

Wound Care (to include dressing changes): Yes_____ No _____ Frequency_____

Ostomy Care: Yes_____ No _____

Durable Medical Equipment: related to ADL care_____

Assessment of member's Activities of Daily Living functions:

	Independent	***Supervision***	***Min Assist***	***Mod/Max Assist***	***Dependent***
Bathing	_____	_____	_____		_____
Grooming	_____	_____	_____		_____
Dressing	_____	_____	_____		_____
Toileting	_____	_____	_____	_____	_____
Bed Mobility	_____	_____	_____	_____	_____
Transfers	_____	_____	_____	_____	_____
Eating	_____	_____	_____	_____	_____

Please include any additional information and documentation to support members requested hours.

Caregiver Information

List all responsible caregivers in the home. Provide a brief description of these caregivers as well as caregiver work / school / medical conditions that limit the availability and duration of the caregivers to care for the member. Please include back-up caregiver information when available.

_____

_____

_____

Please submit all that apply in regards to caregiver's availability:

- ✓ Submit work verification from caregiver's employer noting what hours the caregiver is expected to work
- ✓ Submit documentation from caregiver's school Registrar's office verifying enrollment and class schedule
- ✓ Submit documentation from caregiver's doctor, outlining caregiver's disability including prognosis and expected duration of the limitation

Services Requested for School / School Bus Transportation

This section requires accompanying documents to support the request. Please include the following documents: a copy of this member's current Individualized Education Plan (IEP), school calendar for the current school year and bus schedule with drop-off and pick-up times when applicable.

Name of School_____
Name of School Nurse _____ Phone number_____

If information is available, please explain the skilled nursing and/or unskilled care that is required while member is in school or on school transport._____

_____

_____

Signature and Attestation

Ordering Physician Name_____ NPI #_____

Facility / Practice Name _____

Physician Address_____
Physician Phone number / Fax _____

ATTESTATION:
I hereby attest the information included in this document is true, accurate and complete to the best of my knowledge. Additionally, I deem that the services requested are medically necessary. (Parental requests can be considered in making medical necessity determinations, however, this request is made under ***your signature*** and is similar in nature to a prescription for medication; your professional judgement for the need of a prescription medication is not predicated on patients' requests but medical need. In addition, requests that are in excess of that which are medically necessary are subject to CMS' Fraud, Waste and Abuse policies and could carry associated penalties.)

Physician Signature____

Date____