Prior Authorization and Certificate of Medical Necessity for Private Duty Nursing and Home Health Aide

Please complete ALL sections of this form. Fax the completed form and any supporting documentation to Delaware First Health Prior Authorization at 833-967-0502. **Incomplete information or illegible forms will delay processing.**

Date:

MEMBER INFORMATION		
Member Name:	Member ID:	Date of Birth:
Caregiver Name:	Caregiver Phone Number:	
Diagnosis:	ICD-10 Code:	

SERVICING PROVIDER	
Name:	NPI Number:
Contact Name:	Phone Number:

TYPE OF REQUEST		
☐ Initial Request (up to 60 days)	☐ Concurrent Request (up to 180 days)	☐ Change in Medical Condition/Needs (up to 180 days)

LEVEL OF CARE	
☐ Private Duty Nursing CPT Code: S9124 LPN **OR** CPT Code: S9123 RN	☐ Unskilled Home Health Aide CPT Code: G0156
☐ Please check here if services are requested via Self-Directed Attendant Care CPT Code: S5130 U2	
PLEASE NOTE: Either PDN or HHA Level of Care must be required for Self-Directed Attendant Care	

TYPE OF PDN HOURS		
☐ Sleep	☐ Work/Daycare	☐ Other:

SERVICE PERIOD See Type of Request Section for timeline guidance	
Start Date:	Service End Date:

PDN SERVICE DAYS AND TIMES Indicate days per week and number of hours per day the PDN services are requested	
☐ Sunday	Number of Hours per Day Requested:
☐ Monday	Number of Hours per Day Requested:
☐ Tuesday	Number of Hours per Day Requested:
☐ Wednesday	Number of Hours per Day Requested:
☐ Thursday	Number of Hours per Day Requested:
☐ Friday	Number of Hours per Day Requested:
☐ Saturday	Number of Hours per Day Requested:
Total Requested Hours per Week:	Total Requested Hours per Month:

PAST MEDICAL HISTORY Include all relevant history including hospitalization. Attach additional documentation as needed

CURRENT MEDICATION Attach supplemental sheet if necessary			
Medication	**Route**	**Frequency**	**Dosage**

SERVICE NEEDS Describe the activities of PDN skilled nursing and/or unskilled services to be provided during the hours and days being requested.

SUPPORTING CLINICAL INFORMATION			
☐ Enteral Feeds	☐ Bolus Feeds		Frequency:
☐ Continuous Feeds		☐ PO Feeds	
☐ IV Catheter	Type (Other):		Frequency:
☐ TPN	Frequency:		Duration:
☐ Tracheostomy or Other Artificial Airway:			
☐ Ventilator		Ventilator Settings:	
Hours per Day on Ventilator:	Which Hours:	☐ Continuous	☐ Sleep Only
Most Recent Recorded Oxygen Saturation Level:		Date:	
☐ Oxygen ☐ Continuous ☐ Intermittent ☐ PRN		Pulse Ox ☐ Yes ☐ No	
☐ Skin Care Needs			
Wound Care (incl. dressing changes) ☐ Yes ☐ No Frequency:		Ostomy Care ☐ Yes ☐ No	
Seizures ☐ Yes ☐ No			
Average Number of Seizures per Day:	Average Seizure Duration:		Interventions Other:
Date of Last Seizure:	Interventions Used:		
Durable Medical Equipment in Use:			

ASSESSMENT OF MEMBER'S ACTIVITIES OF DAILY LIVING FUNCTION	
Bathing ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent	Grooming ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent
Dressing ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent	Toileting ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent
Bed Mobility ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent	Transfers ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent
Eating ☐ Independent ☐ Supervision ☐ Min Assist ☐ Mod/Max Assist ☐ Dependent	

SERVICES REQUESTED FOR SCHOOL AND SCHOOL BUS TRANSPORTATION	
This section requires accompanying documents to support the request. Include the following documents: • A copy of this member's current Individualized Education Plan (IEP). • School calendar for the current school year. • Bus schedule with drop-off and pick-up times, if applicable.	
Name of School:	
Name of School Nurse:	Phone Number:

If possible, please include explanation of member's required PDN needs while in transport or school that cannot be met by services provided.

CAREGIVER INFORMATION
List all responsible caregivers in the home. Briefly describe caregiver and caregiver's work, school, and medical conditions that limit the availability and duration of the caregiver to care for the member. Include backup caregiver information.
Please submit all that apply regarding 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.

SIGNATURE AND ATTESTATION	
Ordering Provider Name:	Provider NPI:
Facility/Practice Name:	
Provider Address:	
Provider Phone Number:	Provider Fax Number:
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.*	
Provider Signature:	Date: