



**PRIVATE DUTY NURSING/EXTENDED HOME HEALTH AIDE
 PRIOR AUTHORIZATION REQUEST FORM**

Form must be submitted with current plan of care signed by physician. Please submit this form and plan of care to the email address listed above.

Date:		
GENERAL INFORMATION		
Private Duty Nursing		Extended Home Health Aide
First Date of Service:	Last Date of Service:	
Primary Diagnosis Code:	Secondary Diagnosis Code(s):	
Procedure Code(s):	Quantity:	
Procedure Description:		
RECIPIENT INFORMATION		
Medicaid ID (9 digits):	Date of Birth:	Sex: M F
Last Name:	First Name:	
PROVIDER INFORMATION		
Referring Provider Name:		
Referring Provider NPI:	Referring Provider Taxonomy:	
Address:		
Point of Contact Name and Title:		
Email:	Phone:	
<i>Note: The determination notice will be sent to the listed Point of Contact.</i>		
Servicing Provider Name:		
Servicing Provider NPI:	Servicing Provider Taxonomy:	
Email:	Phone:	
Number of Hours Per Week:	RN	LPN HH Aide

List the number of adult caretakers in the home:

For each caretaker listed above, list the number of hours employed or at school outside of the home per week:

If more than 1 adult caretaker, list the total number of hours that ALL caretakers are typically employed or at school outside the home at the same time (do not include hours the child is in school):

Additional notes about parent/guardian's schedule and needs:

Note: Hours of employment or school should include typical travel times to and from employment/school.

I certify that the information given in this form is a true and accurate medical indication for the procedure(s) required.

Provider name (please print) _____

Provider Signature _____ Date _____