



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

Form must be submitted with current plan of care signed by physician.

NOTE: ALL FIELDS ARE REQUIRED

| | | |
|------------------------------------------------------------------------------------|----------------------------------|------------------|
| 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: | | |
| Fax: | 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: | |
| Fax: | Phone: | |
| Number of Hours Per Week: | RN | LPN HH Aide |

Parent/Guardian's Schedule and Needs: