



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

**PRIVATE DUTY NURSING (PDN)
PRIOR AUTHORIZATION REQUEST**

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____	DATE REQUESTED: _____
ADDRESS: _____ _____	RECIPIENT MEDICAID ID #: _____
	DOB: _____

MEDICAL CARE/TREATMENT AND CLINICAL INFORMATION

1. Medical documentation must be attached and documented to support the request for PDN (485, discharge summary and recent two week nursing notes), as well as to provide additional clinical information to support the level of care. The referring physician or appropriate specialist must complete the following information:

Name of Physician Requesting PDN: _____

Address of Physician: _____

Phone Number: _____

Fax Number: _____

2. Along with the attached documents, you may also explain below why the recipient requires care by a registered nurse:

****Note- Physician signature required annually and when the plan of care is updated based on the recipient's needs.**

3. Summary of recent health history for initial authorization OR 90 day summary for extension of PDN services:

- Hospitalizations:
- Emergency room visits:
- Surgery (may submit a discharge summary):
- Illnesses:
- Changes in condition:
- Changes in medications or treatment:
- Family/caregiver update:

Other pertinent information:

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

*Please submit supporting documentation for verification of above information
Approval is a determination that the services requested are medically necessary and not a guarantee of payment.*



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Recipient's Last name:	First Name:	MID:
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HOME ENVIRONMENT

4. Household members living with the child:

Name	Age	Relationship to Child	Any major health problems

6. Number of care givers: _____

7. Number of care givers who work or attend school outside of the home: _____

a. Care giver's name: _____ # of hrs/days working: _____

Days M Tu W Th F Sa Su Every Weekend

Nights M Tu W Th F Sa Su Alternating Weekends

b. Care giver's name: _____ # of hrs/days working: _____

Days M Tu W Th F Sa Su Every Weekend

Nights M Tu W Th F Sa Su Alternating Weekends

8. Are the Parents in the home while PDN is being provided? Yes No

9. Can PDN be safely provided in a home setting? Yes No

10. Contact person for PDN Care plan: _____

SCHOOL

11. Is recipient currently in school/day program (out of home)? Yes No

If yes, how many hours? _____ Per day _____ Per week (Include travel time) for school year

How many hours? _____ per day _____ per week (include travel time) for summers and vacations

12. Do they have a nurse at school? Yes No

13. Do they have an aide at school? Yes No

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8 Commerce Drive ■ 2nd Floor ■ Bedford, NH 03110 ■ FAX: (866) 499-9334 ■ PHONE: (866) 499-9335



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Recipient's Last name:	First Name:	MID:
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HEALTH INSURANCE/OTHER PUBLICLY FUNDED PROGRAMS

14. Name of private health insurance: _____

15. Private health insurance number: _____

16. What has private health insurance authorized: _____

17. Name of other publicly funded programs that the beneficiary is being served under: _____

PROVIDER INFORMATION: (Name of Medicaid enrolled Private Duty Nursing Agency, R.N., or Supervising R.N. or the Medicaid enrolled LPN who will provide service.)

18. Provider # 1: _____ Start of Service Date: _____

Provider Name: _____

Street Address: _____

Medicaid Provider number: _____ Phone Number (____) _____ - _____

Provider Signature: _____

19. List all other in home providers

All in Home Providers

20. LNA Services provided? Yes No

21. Number of hours of LNA services provided: _____/week

22. Agency providing LNA services: _____

23. Are Skilled Nursing Visits (SNV) being provided? Yes No

24. Number of hours of SNV's services provided: _____/week

25. Agency providing SNV's services: _____

I certify that the information supplied in this document constitutes true, accurate and complete information and is supported in the medical record of the recipient. I understand that the information I am supplying will be utilized to determine approval of services resulting in payment of state and federal funds. I understand that falsifying entries, concealment of material fact, or pertinent omissions may constitute fraud, which may result in fines or legal action by the NH Medicaid program.

Signature of _____ Date _____

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