



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

Fax: 855-445-4239

PLEASE COMPLETE ALL THE SECTIONS ON THIS FORM

Date ____/____/____

Member Name _____

Health Options 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:

	<i>Independent</i>	<i>Supervision</i>	<i>Min Assist</i>	<i>Mod/Max Assist</i>	<i>Dependent</i>
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 _____