NC DMA PRIVATE DUTY NURSING (PDN)
PRIOR APPROVAL REFERRAL FORM

DMA-3061

For initial PDN requests, submit either a) this form along with a DMA 3075 or b) a physician's letter of medical necessity.

PATIENT INFORMATION

Name: _____

Address: _____ Phone Number: _____

MID #: _____Medicare #: _____Birthdate: _____ Sex: _____

RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name: _____

Address: _____

Phone Number: _____ Relationship: _____

CAREGIVER INFORMATION

Name: _____

Address: _____

Phone Numbers: work_____ home_____

Relationship to Recipient: _____

Hours/Day Available to Care for Recipient: _____

PHYSICIAN INFORMATION

Community Attending's Name: _____

Address: _____Phone Number: _____

Names and Phone Numbers of Other Physicians Ordering Care: _____

_____

NURSING AGENCY INFORMATION

PDN Agency: _____

Address: _____

Nursing Contact Person: _____Contact's Phone Number: _____

PDN Provider Number: _____

INSURANCE INFORMATION

Insurer's Name: _____

Address: _____

Contact Person & Phone Number: _____

Policy or ID Number: _____Amount of PDN Covered by Insurance: _____

MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN: _____

_____

_____

Primary nursing interventions and the frequency with which these are performed at home: _____

_____

_____

_____

_____

Physician Orders for Daily Hours and Weeks' Duration: _____

_____

Decreasing Hours: _____

Referred by Name/Agency: _____

Phone Number: _____

Fax this form to CSC at: (855) 710-1964

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp