NC DMA PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

DMA3075

A. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Requested SOC date: _____ * Complete form within 15 business days of the start of care date and submit to NC DMA.

1. Patient Name: _____ 2. Address: _____

3. Phone Number: _____ ____ 4. Recipient ID #: _____

5. Date of Birth: _____6. Diagnosis: _____

_____

7. Prognosis and expectations of specific disease process: _____

8. Date of last physician assessment: _____

9. Services requested and why: _____

10. Specify how many hours/days/weeks requested: _____

11. Informal caregivers' availability and training received: _____

Technology Requirements and Nursing Care Needs

12. Ventilator dependent? ☐ No ☐ Yes Type: _____

13. Hours per day on ventilator: _____

14. Oxygen? ☐ No ☐ Yes Actual liters per minute and hours per day required: _____

15. Continuous prescribed rate? _____ or adjusted daily or more often? (specify): _____

16. Maintain sats > _____% Frequent need for adjustments and interventions? _____

17. Non-ventilator dependent tracheostomy? Circle one. ☐ No ☐ Yes

18. Name of Provider Agency: _____

19. Requesting Provider #:_____NPI: ☐ Atypical: ☐ 20. Taxonomy: _____

21. Address: _____ 22. Nine Digit Zip Code: _____

23. Does that patient have insurance in addition to Medicaid? ☐ Yes ☐ No

24. Is PDN covered by private insurance? ☐ Yes ☐ No If Yes, explain coverage: _____

_____

25. Date of last approval period: _____

26. Current attending physician: _____

27. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____

_____

_____

_____

_____

_____

_____

28. Date of last weight (adults), height and weight for pediatric recipients: _____

29. Date of last examination by MD (name of MD): _____

30. Changes in recipient's condition: _____

_____

_____

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Page 2

31. Home visit observations. Safety of environment, and caregiver information: _____

_____

_____

32. Critical incidents with the recipient (hospitalizations, falls, infections, etc): _____

_____

_____

33. Therapies recipient is receiving (PT, OT, ST, RT, etc): _____

_____

34. Emergency plan of care if nurse is not available; _____

_____

35. Training needs: _____

36. Education provided, return demonstrations and identification of ongoing needs: _____

_____

_____

_____

Nurse Signature and Title:_____ Date:_____

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

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