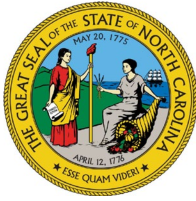

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

Private Duty Nursing (PDN) Change Request Form – DHB-3511

Instructions: Complete the General Information sections, select the type of change request, complete the applicable sections and submit requested documentation to NC Medicaid.

General Information	
Beneficiary Name:	
MID #	
PDN Provider Agency Name:	Provider NPI #:
Total PDN hours currently approved (specify home and school hours if applicable):	
Please select the type of change request.	
☐ Short-term Increase in hours	☐ Notification of change in caregiver availability
☐ Permanent change in approved hours	☐ Notification of change in beneficiary school enrollment
☐ Weaning of a medical device evaluation	☐ Notification of change in private insurance coverage
Option 1: Request for Short-Term Increase in Hours	
Total number of requested hours per week (or titration, if applicable): *Note: A short-term increase in PDN services is limited to a maximum of six calendar weeks.*	
Requested effective date of change:	
Submit the following documentation: ☐ Attending physician-signed order detailing the requested hours with a requested effective date. **<u>AND one of the following:</u>** For new medical technology immediately post-hospital discharge: ☐ Hospital progress note detailing new medical technology. For an acute, temporary change in condition causing increased amount and frequency of nursing interventions: ☐ Hospital discharge summary (post-hospital discharge) or clinical notes detailing condition. For a family emergency when the secondary caregiver requires additional support because of availability or need for reinforcement of training: ☐ Documentation from the primary caregiver's physician detailing the condition.	

Private Duty Nursing (PDN) Change Request Form – DHB-3511

Option 2: Request for Permanent Change in Approved Hours
Total number of requested hours per week:
Requested effective date of change:
Reason for request:
Submit the following documentation: ☐ Attending physician-signed order detailing the requested hours with a requested effective date. ☐ Hospital discharge summary (post-hospital discharge) or clinical notes from last two visits detailing condition ☐ At least five non-consecutive days of nursing notes
Option 3: Weaning of a Medical Device Evaluation
Requested continued hours:
Medical device discontinued and date of removal:
Submit the following documentation: ☐ Attending physician-signed order detailing the requested hours and discontinuing all interventions associated with medical device weaned. ☐ Hospital discharge summary (if from hospital discharge) or clinical notes from the last visit detailing condition ☐ At least five non-consecutive days of nursing notes
Option 4: Notification of Change in Caregiver Availability
Total number of requested hours per week:
Requested effective date of change:
Caregiver name:
Relationship to beneficiary:
Change in employment or college course status:
Submit the following documentation:

Private Duty Nursing (PDN) Change Request Form – DHB-3511

☐ Attending physician-signed order detailing the requested hours with a requested effective date.

☐ Employment verification or official class schedule if requesting an increase in hours due to employment or college course enrollment.

Option 5: Notification of Change in Beneficiary School Enrollment
Total number of requested hours per week:
Requested effective date of change:
Name of school: School district:
What is the typical school schedule? Start: ____________ End: ____________ How many days per week? _____________ *Note: Please include transportation time if a nurse must accompany beneficiary.*
What type of support does the beneficiary have in school? ☐ None ☐ 1:1 support staff ☐ School nurse ☐ Skilled nurse
If skilled nursing support is provided, are the hours billed to NC Medicaid by the LEA by school contract? ☐ Yes ☐ No If No, please specify why.
Submit the following documentation: ☐ Attending physician-signed order detailing the requested hours with a requested effective date.

Option 6: Notification of Change in Private Insurance Coverage
Primary insurance company name, # of hours/week covered, and the dates of coverage:
Number of requested hours per week through NC Medicaid:
Submit the following documentation: ☐ Private insurance Explanation of Benefits document

Nurse Attestation and Signature
Nurse signature and title:
Date:
"I hereby attest that the information contained herein is current, complete and accurate to the best of my knowledge and belief."