NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Private Duty Nursing (PDN) Discharge Summary Form – DHB-3513

Instructions: The form below must be completed in its entirety and submitted to NC Medicaid within five business days of discharge.

General Information	
Beneficiary Name:	
MID #	
PDN Provider Agency Name:	Provider NPI #:
Discharge Information	
Last date PDN services provided:	
Missed shift hours: *Note: Missed shift hours during the authorization period shall be provided to the beneficiary or legal guardian upon request.*	
Reason for discharge:	
Condition at time of discharge:	
Physician name and date notified:	
*If the physician is discharging the beneficiary from PDN services, include the following documentation to support this request: ☐ Attending physician-signed order to include last date of service and reason for discharge.	
Nurse Attestation and Signature	
Nurse signature:	
Date:	
"I hereby attest that the information contained herein is current, complete and accurate to the best of my knowledge and belief."	