Ohio Department of Medicaid

PRIVATE DUTY NURSING (PDN) SERVICES REQUEST

☐ **INITIAL** ☐ **RECERTIFICATION** *(form due 14 to 30 days before expiration of existing PA)* ☐ **CHANGE** *(document change requested in appropriate section)*

Prior Authorization (PA) requests for clients who are not Medicaid eligible on the date of service will automatically be denied. To avoid this, providers must determine consumer eligibility before requesting prior authorization.

CONSUMER INFORMATION *(Print or type information. Illegible and incomplete forms will be returned unprocessed.)* | Date Request Submitted

Consumer Name *(First)* | Middle Initial | Last Name

Street Address | City | State | Zip Code

Phone Number *(Area Code and Number)* | County of Residence

Medicaid Number *(12 digits)* | Date of Birth *(mm/dd/yyyy)*

Name of Parent or Guardian *(if applicable)* | Phone Number(s)

Waiver Type *(Check which applies)*

☐ ODA-Administered Waiver ***(case manager must submit this form)*** ☐ DODD-Administered Waiver ***(SSA must submit this form)***

☐ No Waiver ***(upload this request form via MITS)***

I am requesting to receive private duty nursing services. I have authorized this case manager/SSA or provider to submit this request as written. I authorize Medicaid, the case manager/SSA, and the provider listed below, or the ODA-Administered or DODD-Administered Waiver case manager/SSA to exchange protected health information related to the assessment for and provision of private duty nursing services contained within this request.

Consumer, Guardian or Authorized Representative's Signature ***(Required within 30 days prior to request)*** | Date

PROVIDER INFORMATION ***(Complete section in its entirety for all requests.)***

Provider *(First)* or Agency Name | Middle Initial | Last Name

Street Address | City | State | Zip Code

Phone Number | Fax Number | Email Address

Ohio Medicaid Provider Number *(7 digits)* | National Provider Identifier Number | Nursing License Number *(required only for independent providers)*

Ordering Physician's Name | Ordering Physician's NPI# ***(required)***

The individual submitting this form certifies that the information provided is true, accurate, and complete. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal or State funds may be prosecuted under Federal or State laws.

ODA CASE MANAGER OR DODD SERVICE SUPPORT ADMINISTRATOR (SSA) INFORMATION *(If individual is a recipient of an ODA or DODD –administered waiver service. Request MUST be submitted to Medicaid via the CASE MANAGER or SSA, not the provider)*

Case Manager or SSA Name | Phone Number & Extension

Fax Number | Email Address

NOTE: Prior approval by ODJFS only authorizes service delivery. It does not guarantee a consumer's Medicaid eligibility
It is the provider's responsibility to check* a consumer's Medicaid *eligibility at least monthly.

REQUEST FOR PDN SERVICES *ABOVE* THE ALLOTED 56 hours/week - 60-DAY POST-HOSPITAL STATE PLAN BENEFIT

Process:

1. The consumer's attending physician identifies the need for PDN hours above what the State Plan 60 day Private Duty Nursing Post- Hospital Benefit provides.
2. An agency or independent provider must be chosen.
3. A signed letter must be obtained from the physician that substantiates the need for the increased PDN hours and sent with this PDN request form. The letter must contain at minimum the following:
   - The current diagnosis and the history of the illness
   - The estimated amount, frequency and duration of the services
   - The expected skilled, continuous nursing interventions with the frequency of those interventions specified.
4. Case managers or SSA's must submit PDN requests for individuals on an ODA or DODD administered waiver. They may do so via email or fax and must include a signed ODM 02374 form and physician letter.
5. Providers must submit PDN requests for individuals who are not on a waiver via MITS, uploading the signed PDN request form ODM 02374 and signed physician letter.

NOTIFICATION OF PROVISION OF EMERGENCY SERVICES ***(Valid for individuals who currently have an approved PA.)***

Pursuant to OAC 5160-12-02.3(E) (1) PDN services may be delivered in an emergency and a new PDN authorization obtained after the delivery of services. **The PDN services must be medically necessary in accordance with OAC 5160:3-1-01 and the services must be necessary to protect the health and welfare of the consumer.** (Emergency services are provided outside normal State of Ohio office hours when prior approval cannot be obtained.)

****Notification must be made via leaving a message on the PDN manager's phone line at 614-466-6742 or emailing PDN_BCSP@Medicaid.Ohio.gov as well as submitting a request via MITS no later than the first business day following service provision.**

List Emergency Services Provided	
Reason for Emergency	
Number of Units of Service Provided Per Day	Number of Days of Service Provided Per Week
Consumer Name	Medicaid Number

CHANGE IN SERVICE REQUEST ***(Complete only for those with current active PA's to add or change providers, increase, decrease or terminate services)***

Reason/rationale for change request (please include justification and supporting documentation):

Amount of services currently authorized **Existing PA authorization span** **From: to:**	**Amount of services being requested** **Requested duration of change** **From: to:**

Fee for Service Medicaid Recipients

Providers *must* submit requests

via the Medicaid MITS Web Portal:

http://Medicaid.ohio.gov/providers/mits.aspx

**** Provider faxes or emails will not be accepted for PDN requests.***

Waiver Recipients

DODD Service Support Administrator or PASSPORT Case Managers

***must* email the completed form to:**

pdn_bcsp@Medicaid.ohio.gov

or FAX: 614-387-7661

Attention: Ohio Department of Medicaid PDN Manager

Bureau of Long Term Care Services and Supports

For questions call: 614-466-6742