Ohio Department of Medicaid

PRIVATE DUTY NURSING (PDN) SERVICES REQUEST

☐ **INITIAL** ☐ **RECERTIFICATION** ☐ **CHANGE**

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

CONSUMER INFORMATION *(Complete entirely for all requests.)*			Date of Request
Consumer Name *(First, MI, Last)*			
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		Phone Number(s)	

Waiver Type *(Check)*
☐ ODA-Administered Waiver ☐ DODD-Administered Waiver ☐ No Waiver

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

Consumer's or Authorized Representative's Signature	Date

PROVIDER INFORMATION *(Complete entirely for all requests.)*			
Provider Name *(First, MI, Last)*/Agency			
Street Address	City	State	Zip Code
Phone Number	Fax Number	Email Address	
Ohio Medicaid Provider Number 7 digits *(Required)*	National Provider Identifier Number	Nursing License Number	

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 OR DODD CASE MANAGER INFORMATION
(Request MUST be submitted to Medicaid by the CASE MANAGER if receiving ODA-Administered or DODD –Administered waiver services.)

Case Manager Name	Phone Number
Fax Number	Email Address

Medicaid APPROVAL ***(For State use only)***

PDN Services Approved ☐ YES ☐ NO	Number of Base and Sub Units Per Day, and Number of Hours Authorized Per Week
Scope of Services Approved	
Duration of Services Approved From To	
ODJFS Approved By	Date
Additional Comments	

NOTE: Prior approval by Medicaid 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 each month.

REQUEST FOR PDN SERVICES BEYOND THE 60-DAY POST-HOSPITAL STATE PLAN BENEFIT

The consumer's attending physician identifies the need for PDN beyond what the State Plan 60 day Private Duty Nursing Post Hospital Benefit provides. An agency or independent provider must be found and agree to take care of the consumer. The request for PDN services must come from the provider or case manager if consumer is enrolled on an ODA-Administered or DODD-Administered waiver. A signed letter must be obtained from the physician that substantiates the need for the increased PDN hours and sent with the PDN request form. The letter must contain at minimum the following:

- The current diagnosis and the history of the illness
- The projected date of hospital discharge
- The estimated amount, frequency and duration of the services
- The expected skilled, continuous nursing interventions with the frequency of those interventions specified.

A temporary prior authorization number may be issued for a limited time until a face to face assessment can be completed.

NOTIFICATION OF PROVISION OF EMERGENCY SERVICES *(Complete for recertification requests only.)*

Pursuant to OAC 5101:3-12-02.3(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 5101:3-1-01 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 submitted 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***

REQUEST FOR CHANGE IN SERVICES (INCREASE, DECREASE, TERMINATION, WITHDRAWAL)*

*(Complete for **recertification requests only**.)*

Amount of Services Currently Being Received	Duration of Services Currently Being Received *(List dates)* From To
Amount of Services Being Requested	Duration of Services Being Requested *(List dates)* From To
Reason for Request *(If increase, please include justification for increase with supporting documentation (Physician orders, visit notes, increased skilled nursing interventions, 485, etc)*	

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.

Independent and Agency Providers

This form must be submitted via the Medicaid MITS Web Portal:
http://medicaid.ohio.gov/providers/mits.aspx
No faxes or emails will be accepted for PDN requests.

For DODD Service Coordinators and PASSPORT Case Managers ONLY

Email or fax the completed form to:
Ohio Department of Medicaid
Bureau of Long Term Care Services and Supports
EMAIL: pdn_bcsp@medicaid.ohio.gov
FAX: 614-387-7661
If questions call: 614-466-6742