NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

REQUEST FOR SERVICE AUTHORIZATION
FOR PRIVATE DUTY NURSING AND TRANSFER OF UNITS
(Fee-for-Service (FFS) Program Only – Not for Managed Care program use)
Instructions for filling out this form are attached.

*****PLEASE PRINT OR TYPE ALL INFORMATION (All fields required)*****

RECIPIENT INFORMATION **TODAY'S DATE:**

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS CODES: _____

ALTERNATE INSURANCE: NAME OF PLAN _____

PROVIDER INFORMATION

CONTACT PERSON: _____ EMAIL: _____

TELEPHONE #: _____ FAX #: _____

AGENCY NAME: _____ AGENCY MEDICAID ID #:_____

DESCRIPTION OF PRIVATE DUTY NURSING SERVICES

NOTE:DAYTIME/EVENING HRS (6AM TO 10PM) NIGHT/WEEKEND HRS (10PM-6AM)
INTENSIVE LEVEL OF CARE: VENT DEPENDENT 12 + HRS/DAY

CPT Code	Modifier	Number of Hours per Week	Days of Week and Hours/Day (Example: M, Tu, Th 7am-5pm)	Dates of Service		STATE USE ONLY
				Start Date	End Date	
S9123/S9124						
S9123/S9124						
S9123/S9124						

FOR STATE USE ONLY

ADD, DELETE OR TRANSFER HOURS. USE ONLY FOR REVISIONS TO CURRENT SERVICE AUTHORIZATIONS

Current Service Authorization #: | Reason for Change:

Number of HOURS PER WEEK to ☐ ADD ☐ DELETE ☐ TRANSFER TO ANOTHER AGENCY	TO CPT Code or Agency		Modifier	CHANGE DATE	CURRENT DATES OF SERVICE	
	CODE OR AGENCY	MODIFIER		Change Start Date	Current Service Authorization Start Date	Current Service Authorization End Date

OTHER PROVIDER INFORMATION List all other PDN Providers in the home:

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 271-8194

ADDITIONAL INFORMATION

Household members living with the recipient:

Name	Age	Relationship to child	Any major health problems

Number of caregivers:_____
Number of caregivers who work or attend school outside the home:_____

SCHOOL

Is recipient currently in school/day program (out of home? If on vacation or summer break, please check yes.) □ YES □ NO

If yes, how many hours_____ per day, _____ per week (include travel time) for school year

How many hours _____ per day _____ per week (include travel time) for summers and vacations

Do they have a nurse at school? □ YES □ NO

Do they have an aide at school? □ YES □ NO

PHYSICIAN'S ORDER, NURSING ASSESSMENT AND PLAN OF CARE

Pursuant to He-W 540.07© Service Authorization information required shall include, but not be limited to a written, signed and dated physician's order, as described in He-W 540.06(a); the nursing assessment, as described in He-W 540.06(b); and the plan of care, as described in He-W 540.06(c).

□ **I certify that I have attached a Physician's order and a Nursing Assessment and a Plan of Care.**

Signature **Date** **Printed Name** **Title**

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

INSTRUCTIONS FOR PRIVATE DUTY NURSING: FORM 272PDN FFS REQUEST FOR PRIVATE DUTY NURSING SERVICE AUTHORIZATION AND TRANSFER OF UNITS

This form must be filled out pursuant to He-W 540.07(c) Service Authorization information required shall include, but not be limited to a written, signed and dated physician's order, as described in He-W 540.06(a); the nursing assessment , as described in He-W 540.06(b); and the plan of care, as described in He-W 540.06(c).

Please note that before this form is filled out, **it is your responsibility to verify eligibility** of the recipient for the Fee-for-Service (FFS) program. That can be done by calling the number on the back of the recipient's Medicaid card; calling Conduent at 866-291-1674; looking directly in the MMIS system; or using the software your office has to access the information.

The first two sections are the Recipient Information and Provider Information and should be filled out accordingly. Note if there is an Alternate Insurance, NH Medicaid is the payer of last resort. We will need an Explanation of Benefit from the first insurance company or a denial letter in order to process your request. **Please do not request an authorization "just in case" private insurance doesn't cover.

The next section is for requesting **NEW** private duty nursing hours. NH Medicaid approves all nursing, whether RN or LPN under the S9123/S9124 range codes. Fill in the modifier, the number of hours/units **per week**, the days of the week and hours of the day, and the start and end date of service.

If you need to change an existing SA, use the next part of this form. NOTE: if you need different dates of service, you will need to make out the top section on a new form.

Please do not combine both a new request and a change request on the same form.

- Write in the current SA number and reason for the change.
- Then fill in the CPT Code or Agency the units are coming from and the modifier as needed.
- Check the box for add (if you need more hours during these dates of service,) change (if you need to change from RN to LPN or time of day) or transfer (if you are giving units you cannot fill to another agency)
- Enter the number of hours/units to be changed.
- Enter the new CPT Code or Agency and modifier.
- Enter start and end date of the current Service Authorization.

On the second page is additional information and school information needed to process your request, please fill it in completely.

The section following is the legal information with references to the Medicaid rule, for your convenience. The signature should be that of the person completing the form.

To submit documents request a secured email link, by emailing ServiceAuthorizationFFS@dhhs.nh.gov. In the subject line write Requesting Approval for: then choose DME, Incontinence, Therapy etc. You will receive a secured email thread. Alternatively you can use your own process for securing Protected Health Information in documents sent by email. Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Return all documentation and the Service Authorization Request form to SerivceAuthorizationFFS@dhhs.nh.gov or fax to: 603-271-8194.

If the information sent is incomplete, you will receive a request for more information. This is not a denial. Send in the information as above for the request to be reconsidered.

If all information is complete and criteria is met, you will receive a form from the state with the approval information. The approval number will be in the box on the top right corner.