AmeriHealth Caritas
Delaware

Certificate of Medical Necessity for
Private Duty Nursing and Home Health Aide
Fax: 866-497-1384

PLEASE COMPLETE ALL THE SECTIONS ON THIS FORM

Date____/_____/_____

Member Name _____

Member ID#_____Member's Date of Birth_____/_____/_____

Parent / Guardian / Caregiver Name:_____Phone:_____

Diagnoses_____

Type of Request:

Initial Request_____
Annual Review_____
Change in Medical Condition/Needs_____

Other (Explain): _____

Level of care requested: Private Duty Skilled Nurse (PDN)_____Unskilled Home Health Aide (HHA) _____

Indicate the number of hours/day needed for Parent and Travel time to work or school:

Sleep _____Work _____School _____Travel*_____

Indicate the number of hours/day needed for Member and Travel time to work or school:

Sleep _____Work _____School _____Travel* _____
Please indicate how much time is needed to get to work or school for both parent and member

Other (Explain): _____

_____

Hours requested for each day and/or night of the week: *) be specific with time needed for example if you are asking for 6 hours of time while child is in school specify what you will be doing to warrant the time requested*.

_____

_____

_____

_____

**For the following questions, please attach additional documentation if the space provided is insufficient*

Past Medical History includes: [include all relevant history including hospitalizations

Current medications

Medication	*Route*	*Frequency*	*Dosage*

Provide a narrative explaining skilled nursing needs and medical interventions that must be performed by a nurse and/or unskilled medical needs requires assistance with activities of daily living that the nurse or home health aide would be rendering during the hours that are being requested: _____

_____

_____

_____

_____

_____

_____

_____

SUPPORTING CLINICAL INFORMATION

Enteral Feeding: Yes _____No_____

Bolus Feeds: Yes_____No_____Frequency: _____

Continuous Feeds**:** Yes_____No_____PO Feeds: Yes _____No _____

G Tube : Yes _____ No_____Frequency:_____

IV Catheter: Yes_____No_____Type: (e.g., PICC, Broviac, Peripheral) Frequency of use: _____

TPN: Yes_____No _____Frequency: _____Duration: _____

Tracheostomy or other Artificial Airway YES _____NO_____ Ventilator YES ____NO_____

Ventilator Settings _____

Hours per day on ventilator_____which hours_____Continuous_____Sleep Only_____

Most recent recorded oxygen saturation level_____Date_____

Respiratory Issues(s) Oxygen: Yes_____No_____

Continuous:_____Intermittent:_____PRN: _____

Pulse Ox: Yes_____No _____

Seizures: Yes_____No_____

Average number of seizures per day:_____Average Duration: _____

Interventions (VNS, Diastat, Oxygen, etc.)

Date of member's last seizure & interventions utilized: _____

Wound Care (to include dressing changes): Yes_____No _____

Ostomy Care: Yes_____No _____

Frequency_____

Durable Medical Equipment: related to ADL care_____

Assessment of member's Activities of Daily Living functions:

	Independent	*Supervision*	*Min Assist*	*Mod/Max Assist*	*Dependent*	*Frequency*
Bathing						
Grooming						
Dressing						
Toileting						
Bed Mobility						
Transfers						
Eating						

Please include any additional information and documentation to support members requested hours.

Caregiver Information

List all responsible caregivers in the home. Provide a brief description of these caregivers as well as caregiver work / school / medical conditions that limit the availability and duration of the caregivers to care for the member. Please include back-up caregiver information when available.

_____

_____

_____

Please submit all that apply in regards to caregiver's availability:

- ✓ Submit work verification from caregiver's employer noting what hours the caregiver is expected to work
- ✓ Submit documentation from caregiver's school Registrar's office verifying enrollment and class schedule
- ✓ Submit documentation from caregiver's doctor, outlining caregiver's disability including prognosis and expected duration of the limitation

Services Requested for School / School Bus Transportation

This section requires accompanying documents to support the request. Please include the following documents: a copy of this member's current Individualized Education Plan (IEP), school calendar for the current school year and bus schedule with drop-off and pick-up times when applicable.

Name of School_____

Name of School Nurse_____Phone number_____

If information is available, please explain the skilled nursing and/or unskilled care that is required while member is in school or on school transport *(Please include how the hours that are being asked for will be spent with member)*_____

_____

Signature and Attestation

Ordering Physician Name_____NPI #_____

Facility / Practice Name _____

Physician Address_____

Physician Phone number / Fax _____

ATTESTATION:

I hereby attest the information included in this document is true, accurate and complete to the best of my knowledge. Additionally, I deem that the services requested are medically necessary. (Parental requests can be considered in making medical necessity determinations, however, this request is made under *your signature* and is similar in nature to a prescription for medication; your professional judgement for the need of a prescription medication is not predicated on patients' requests but medical need. In addition, requests that are in excess of that which are medically necessary are subject to CMS' Fraud, Waste and Abuse policies and could carry associated penalties.)

Physician Signature_____

Date_____

Please FAX Completed form and related documents to **Fax: 866-497-1384**