

**NC UHC C&S
PRIVATE DUTY NURSING (PDN)
PHYSICIANS REQUEST FORM**

NC LTSS-3075

Requested SOC date: _____*

Complete form and submit to NC C&S LTSS Pre-service UM Team @ fax # 888-724-8986.

1. Patient Name: _____ 2. Address: _____
3. Phone Number: _____ 4. Recipient ID #: _____
5. Date of Birth: _____ 6. Diagnosis: _____

7. Prognosis and expectations of specific disease process: _____

8. Date of last physician assessment: _____

9. Services requested and why: _____

10. Specify how many hours/days/weeks requested: _____

11. Informal caregivers' availability and training received: _____

Technology Requirements and Nursing Care Needs

12. Ventilator dependent? No Yes Type: _____

13. Hours per day on ventilator: _____

14. Oxygen? No Yes Actual liters per minute and hours per day required: _____

15. Continuous prescribed rate? _____ or adjusted daily or more often? (specify): _____

16. Maintain sats > _____% Frequent need for adjustments and interventions? _____

17. Non-ventilator dependent tracheostomy? Circle one. No Yes

18. Name of Provider Agency: _____

19. Requesting Provider #: _____ NPI: Atypical: 20. Taxonomy: _____

21. Address: _____ 22. Nine Digit Zip Code: _____

23. Does that patient have insurance in addition to UHC(MEDICAID) Yes No

24. Is PDN covered by private insurance? Yes No If Yes, explain coverage: _____

25. Date of last approval period: _____

26. Current attending physician: _____

27. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____

28. Date of last weight (adults), height and weight for pediatric recipients: _____

29. Date of last examination by MD (name of MD): _____

30. Changes in recipient's condition: _____

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31. Home visit observations. Safety of environment, and caregiver information: _____

32. Critical incidents with the recipient (hospitalizations, falls, infections, etc.): _____

33. Therapies recipient is receiving (PT, OT, ST, RT, etc.): _____

34. Emergency plan of care if nurse is not available; _____

35. Training needs: _____

36. Education provided, return demonstrations and identification of ongoing needs: _____

Print Physicians Name: _____

Print Physicians Address & Phone Number: _____

Physicians Signature: _____

Date: _____