UHC C&S PRIVATE DUTY NURSING (PDN)
PRIOR APPROVAL REFERRAL FORM

For initial PDN requests, submit either a) this form along with a NC LTSS-3075 or b) a physician's letter of medical necessity.

PATIENT INFORMATION

Name:_____

Address:_____ Phone Number: _____

MID #:_____UHC MEMBER ID #:_____ Birthdate:_____ Sex:___

RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name:_____

Address: _____

Phone Number:_____ Relationship: _____

CAREGIVER INFORMATION

Name:_____

Address: _____

Phone Numbers: work _____ home _____

Relationship to Recipient: _____

Hours/Day Available to Care for Recipient: _____

PHYSICIAN INFORMATION

Community Attending's Name: _____

Address: _____ Phone Number:_____

Names and Phone Numbers of Other Physicians Ordering Care:_____

_____

NURSING AGENCY INFORMATION

PDN Agency: Address: _____

Nursing Contact Person:_____ Contact's Phone Number:_____

PDN Provider Number: _____

INSURANCE INFORMATION

Insurer's Name:_____

Address:_____

Contact Person & Phone Number:_____

Policy or ID Number:_____ Amount of PDN Covered by Insurance:_____

MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN: _____

_____

Primary nursing interventions and the frequency with which these are performed at home:

_____

_____

Physician Orders for Daily Hours and Weeks' Duration: _____

Decreasing Hours: _____

Referred by Name/Agency: _____

Phone Number: _____