# Medical Necessity Form
# Private Duty Nursing and Shift Care Services

UPMC HEALTH PLAN

TO: UPMC Health Plan
Ancillary Services
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Phone: 412-454-7525 or
1-800-425-7800
Fax: 412-454-5255

Completed forms should be submitted electronically via the Provider OnLine portal.

From: ______________________________

Physician or facility: ______________________________

Contact name: ______________________________

Contact phone: ______________________________

Contact fax: ______________________________

*PLEASE COMPLETE ALL SECTIONS OF THIS FORM.*

Member name: ______________________ Today's date: ______________________

UPMC Health Plan ID #: ______________________ Member date of birth: ______________________

Member diagnosis: ______________________ ICD-10 Code: ______________________

Does member have other insurance? Yes ☐ No ☐ Primary: ______________ Secondary: ______________

Name of insurance company: ______________________________

Type of insurance: ______________________ Name of subscriber: ______________________

Subscriber ID #: ______________ Group #: ______________ Phone #: ______________

| | 1 | 2 |
|---|---|---|
| Name of parent/guardian(s): | ______________ | ______________ |
| Relationship (parent, guardian, foster parent): | ______________ | ______________ |
| Home phone/cell phone: | ______________ | ______________ |
| Work phone: | ______________ | |
| Other individuals living in home (indicate relationship to member and age): | Yes ☐ No ☐ | |
| Parent/Guardian work schedules: Indicate hours each day + travel time. Attach work verification letter from employer(s). | ______________ | ______________ |

Has a family member/caregiver been trained to care for the member? Yes ☐ No ☐

Name of trained caregiver(s) and relationship to member:

Is trained caregiver able, available, and willing to provide care? Yes ☐ No ☐

Skill level requested (PDN): RN/LPN: __________ Personal care/home health aide (HHA): __________ Medical day care: __________

Total hours requested for each day/night of the week with start and end times:

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| **Start:** ☐AM ☐PM ________ | **Start:** ☐AM ☐PM ________ | **Start:** ☐AM ☐PM ________ | **Start:** ☐AM ☐PM ________ | **Start:** ☐AM ☐PM ________ | **Start:** ☐AM ☐PM ________ | **Start:** ☐AM ☐PM ________ |
| **End:** ☐AM ☐PM ________ | **End:** ☐AM ☐PM ________ | **End:** ☐AM ☐PM ________ | **End:** ☐AM ☐PM ________ | **End:** ☐AM ☐PM ________ | **End:** ☐AM ☐PM ________ | **End:** ☐AM ☐PM ________ |

Estimated start date: ______________________ Estimated duration: ______________________

Agency name: ______________________ Phone number: ______________________

***If there is not enough space for all medications, please attach an additional medication list.***

| Medication | Dose | Route | Frequency |
| --- | --- | --- | --- |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ | ____________ |

## *SUPPORTING CLINICAL INFORMATION*

**Ventilator:** Yes ☐ No ☐ Type (e.g., BiPap, CPAP, traditional): ____________

Hours per day on ventilator: ____________

**Trach:** Yes ☐ No ☐ Date inserted: ____________ Type: ____________ Size: ____________

How often is trach *care* performed per day? ____________ Changed (frequency): ____________

How often is *suctioning* performed per day? ____________

**Respiratory Issue(s)/Oxygen:** Oxygen: Yes ☐ No ☐ Liter/minute: ____________ Route: ____________

Continuous: ____________ Intermittent: ____________

Frequency oxygen is utilized (intermittent/nighttime only): ____________

Pulse Ox: Yes ☐ No ☐ Continuous: Yes ☐ No ☐ Intermittent: Yes ☐ No ☐

Nebulizer: Yes ☐ No ☐ Frequency: ____________

Cough Assist Device: Yes ☐ No ☐ Chest percussion: Yes ☐ No ☐ Frequency: ____________

**Enteral Feeding:** Yes ☐ No ☐ Formula: ____________

Bolus Feeds: Yes ☐ No ☐ Amount: ____________ Frequency: ____________ Duration: ____________

Continuous feeds: Yes ☐ No ☐ If yes, please indicate the total hours for continuous feedings with times and rate of administration: ____________ PO feeds: Yes ☐ No ☐

**Ostomy:** Yes ☐ No ☐ Type: ____________

How often is bag emptied? ____________ How often is appliance changed? ____________

**Skin Care:** Incontinent of urine: Yes ☐ No ☐ Incontinent of bowel: Yes ☐ No ☐

Foley catheter: Yes ☐ No ☐ Frequency of catheter care: ____________

Frequency of diaper changes: ____________ Frequency of repositioning per day: ____________
Frequency of PROM: ____________

Wounds: Yes ☐ No ☐ How many: _____ Frequency of wound care: ____________

Locations: ____________ Type of wound care: ____________

**IV Catheter:** Yes ☐ No ☐ Type (e.g., Broviac, PICC, peripheral) ____________

Antibiotics: Yes ☐ No ☐ Frequency: ____________ Duration: ____________

TPN: Yes ☐ No ☐ Frequency: ____________ Duration: ____________

**Seizures**: Yes ☐ No ☐ Diagnosis r/t seizures: ________________ Controlled with current meds: Yes ☐ No ☐

Average number of seizures per day: ____________ Average duration: ______________

Interventions (VNS, Diastat, etc.): ____________________________________________

Date of member's last seizure and interventions utilized: ______________________________

________________________________________________________________

**Behavioral Health, MH/MR Services:** Yes ☐ No ☐

Type of services (e.g., TSS, wraparound services, family–based): ______________________

Please indicate the total hours provided per day for each service: ____________________

Other behavioral health issues:

________________________________________________________________

**Durable Medical Equipment:** Please list all DME equipment in use: ____________________

________________________________________________________________

**Ambulation/ADLs:** Is member ambulatory? Yes ☐ No ☐

List all assistive devices currently used by the member (w/c, walker): __________________

________________________________________________________________

Is a Hoyer lift used? Yes ☐ No ☐

To what degree is member able to perform ADLs? Please check appropriate column:

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

**Therapies:**

Physical _____ Hrs/Wk _____ Occupational _____ Hrs/Wk _____ Speech _____ Hrs/Wk _____ Other _____ Hrs/Wk _____

Are therapies performed in the home setting, as an outpatient, or in school?* ______________

Is the school district a payer for PDN/HHA services during school hours? Yes ☐ No ☐

If yes, please specify the level of care/hours of services provided during school hours per day:

________________________________________________________________

School district: ______________________ Method of transportation: ____________________

Total hours of school attendance daily, including travel time: ______________________

*Please attach current school district calendar.

**Additional Information:**

Other agencies involved in member's care (list name and phone #): ______________________________

Has member applied for/received assistance through any PA state waiver program? Yes ☐ No ☐

If yes, please specify waiver program: ______________________________

**Ordering physician (print):** ______________________________

**Physician phone number:** ______________ **Fax number:** ______________

**Physician address:** ______________________________

**Date of last office visit:** ______________ **Date of next visit:** ______________

**Date of last hospitalization:** __________ **Dx:** __________ **Facility:** __________

**Date of last ED visit:** __________ **Reason:** __________ **Facility:** __________

**Current height:** ______________ **Current weight:** ______________

**Physician signature:** ______________________________

**Contact person:** ______________________ **Date:** ______________



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