



NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
 Date: _____ By: _____
 Dates of Service: _____
 EPSDT: _____ SA #: _____

272PDN FFS
10/2018
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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

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____ DIAGNOSIS CODES: _____

ALTERNATE INSURANCE: NAME OF PLAN _____

PROVIDER INFORMATION

DATE(S) OF SERVICE: _____ CONTACT PERSON: _____

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	
				Start Date	End Date

FOR STATE USE ONLY

ADD, CHANGE OR TRANSFER UNITS USE ONLY FOR REVISIONS TO CURRENT SERVICE AUTHORIZATIONS

Service Authorization #:		Reason for Change:					
FROM CPT Code Or Agency	Modifier	# Hours/Units to <input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> TRANSFER	TO CPT Code or Agency	Modifier	CURRENT Dates of Service		CHANGE DATE
					Current Start Date	Current End Date	Effective Date of Change

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

PLEASE FORWARD THIS INFORMATION TO ATTENTION – MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ FAX: (603) 271-8194



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

Empty box for listing other PDN providers in the home.

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?) 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
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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. Fill in the CPT Code and 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.

Attach the Physicians order, the Letter of Medical Necessity, and clinical notes supporting the request. Fax all documentation and the Service Authorization Request form to 603-271-8194. You will receive a fax from the State with the authorization information or a request for more information.

Once the Request for Service Authorization has been approved by the State you will receive the Authorization Number and other information about the authorization from the State.

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