NEW HAMPSHIRE MEDICAID

For State use only. **APPROVED**
Date: _____ By: _____

Dates of Service: _____

EPSDT: _____SA #: _____

REQUEST FOR SERVICE AUTHORIZATION
FOR PRIVATE DUTY NURSING AND TRANSFER OF UNITS
(Fee-for-Service (FFS) Program Only – Not for Managed Care program use)

*****PLEASE PRINT OR TYPE ALL INFORMATION (All fields required)*****

RECIPIENT INFORMATION

RECIPIENT NAME: _____ DATE OF BIRTH: _____

RECIPIENT MEDICAID ID #: _____DIAGNOSIS CODES: _____

ALTERNATE INSURANCE: _____

Providers are expected to follow all third party payors requirements for payment and all third party obligations shall be exhausted before billing Medicaid, in accordance with 42 CFR 433.139.

PROVIDER INFORMATION

CONTACT PERSON: _____ EMAIL: _____

TELEPHONE #: _____EXT:_____ FAX #: _____

AGENCY NAME: _____ AGENCY MEDICAID ID #:_____

OTHER AGENCIES IN THE HOME: _____

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 **WE USE A RANGE OF PROCEDURE CODES TO COVER BOTH RN AND LPN**

CPT Code	Modifier	Number of Hours per Week	Days of Week and Hours/Day (Example: M, Tu, Th 7am-5pm)	Dates of Service		STATE USE ONLY
				Start Date	End Date	
S9123/S9124						
S9123/S9124						
S9123/S9124						

FOR STATE USE ONLY

ADD OR DELETE HOURS. USE ONLY FOR REVISIONS TO CURRENT SERVICE AUTHORIZATIONS

Current Service Authorization #: | Reason for Change:

Number of HOURS PER WEEK to ☐ ADD ☐ CHANGE ☐ TRANSFER	CHANGE FROM CPT Code & Modifier		CHANGE TO If Transfer to Agency: NAME_____		DATES OF SERVICE	
	CODE	MODIFIER	CODE	MODIFIER	Change Start Date	Change End Date
	S9123/S9124		S9123/S9124			
	S9123/S9124		S9123/S9124			
	S9123/S9124		S9123/S9124			

PLEASE FORWARD THIS INFORMATION TO ATTENTION - MEDICAID MEDICAL SERVICES BY FAX OR MAIL
129 Pleasant St ■ Concord, NH 03301 ■ Email: ServiceAuthorizationFFS@dhhs.nh.gov ■ FAX: (603) 314-8101

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 ATTENDANCE - NOTE IF ON VACATION OR SUMMER BREAK, FILL IN INFOR FOR SCHOOL

Is recipient currently in school/day program (out of home?) □ YES □ NO

If yes FOR SCHOOL YEAR, how many hours_____ per day, _____ per week (include travel time)

If yes FOR SUMMERS AND VACATIONS, How many hours _____ per day _____ per week (include travel time)

Does member have a full time nurse at school? □ YES □ NO

Does member have a full time aide at school? □ YES □ NO

PHYSICIAN'S ORDER, NURSING ASSESSMENT AND PLAN OF CARE, or A Physician SIGNED FORM 485
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**

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