AmeriHealth Caritas Delaware

Certificate of Medical Necessity for Private Duty Nursing and Home Health Aid

Please complete this form and fax it to **1-866-497-1384**.

Date: ____ /____ /_____

Member information

Member name:		
Member ID number:	Member's date of birth:	
Parent / Guardian / Caregiver name:	Phone number:	
Diagnoses:		
Type of request: ☐ Initial request ☐ Annual review ☐ Change in medical condition/needs ☐ Other (explain):		
Level of care requested: ☐ Skilled — private duty nurse (PDN) ☐ Unskilled — home health aide (HHA)		
Indicate the number of hours/day needed for parent and travel time to work or school:		
Sleep:	Work:	School: Travel*:
Indicate the number of hours/day needed for member and travel time to work or school:		
Sleep:	Work:	School: Travel*:
Other (explain):		
Hours requested for each day and/or night of the week: (Be specific with time needed; for example, if you are asking for 6 hours of time while child is in school specify what you will be doing to warrant the time requested).		

***Please indicate how much time is needed to get to work or school for both the parent and member.**

For the following questions, please attach additional documentation if the space provided is insufficient.

Past medical history includes: (Include all relevant history including hospitalizations)

Current medications			
Medication	**Route**	**Frequency**	**Dosage**

Provide an explanation of nursing needs and medical interventions that must be performed by a skilled private duty nurse, and/or medical needs and activities of daily living (ADL) that require unskilled assistance by a home health aide during the hours requested:

Supporting clinical information

Enteral feeding: ☐ Yes ☐ No

Bolus feeds: ☐ Yes ☐ No Frequency:

Continuous feeds: ☐ Yes ☐ No

P.O. feeds: ☐ Yes ☐ No

Gastrostomy tube: ☐ Yes ☐ No Frequency:

IV catheter: ☐ Yes ☐ No

Type: (e.g., PICC, Broviac, peripheral)

Frequency of use:

Tracheostomy or other artificial airway: ☐ Yes ☐ No

Ventilator: ☐ Yes ☐ No

Ventilator settings:

Hours per day on ventilator:

Which hours:

Continuous:

Sleep only:

Most recent recorded oxygen saturation level:

Date:

Respiratory issues(s), oxygen: ☐ Yes ☐ No

Continuous:

Intermittent:

As needed:

Pulse ox: ☐ Yes ☐ No

Seizures: ☐ Yes ☐ No

Average number of seizures per day:

Average duration:

Interventions (e.g., vagus nerve stimulator [VNS], Diastat®, oxygen):

Date of member's last seizure and interventions utilized:

Wound care (to include dressing changes): ☐ Yes ☐ No

Ostomy care: ☐ Yes ☐ No Frequency:

Durable medical equipment related to ADL care:

Assessment of member's activities of daily living (ADL) functions:

	Independent	Supervision	Minimal assistance	Moderate or maximum assistance	Dependent	Frequency
Bathing						
Grooming						
Dressing						
Toileting						
Bed mobility						
Transfers						
Eating						

Please include any additional information and documentation to support the member's requested hours.

Caregiver information

List all responsible caregivers in the home. Provide a brief description of these caregivers as well as work, school, or medical conditions that limit the ability or availability of the caregivers to care for the member. Please include backup caregiver information when available.

Please submit all of the below that apply to caregiver's availability:

- Submit work verification from caregiver's employer noting what hours the caregiver is expected to work.
- Submit documentation from caregiver's school registrar's office verifying enrollment and class schedule.
- Submit documentation from caregiver's doctor outlining caregiver's disability, including prognosis and expected duration of the limitation.

Services requested for school / school bus transportation

This section requires accompanying documents to support the request. Please include the following documents: a copy of this member's current individualized education plan (IEP), school calendar for the current school year, and bus schedule with drop-off and pickup times when applicable.

Name of school:	
Name of school nurse:	Phone number:

If the information is available, please explain the skilled nursing and/or unskilled care that is required while the member is in school or on school transport (i.e., please include how the hours with member that are being requested will be spent).

Signature and attestation	
Ordering physician name:	NPI number:
Facility/practice name:	
Physician address:	
Physician phone number:	Physician fax number:

Attestation:
I hereby attest the information included in this document is true, accurate, and complete to the best of my knowledge. Additionally, I deem that the services requested are medically necessary. (Parental requests can be considered in making medical necessity determinations, however, this request is made under your signature and is similar in nature to a prescription for medication; your professional judgment for the need of a prescription medication is not predicated on patients' requests but medical need. In addition, requests that are in excess of that which are medically necessary are subject to Centers for Medicare & Medicaid Services' fraud, waste, and abuse policies and could carry associated penalties.)
Physician signature:
Date:

Please fax completed form and related documents to Fax: **1-866-497-1384.**

AmeriHealth Caritas™
Delaware

www.amerihealthcaritasde.com