In lieu of Letter of Medical Necessity, providers have the option to use this form.

Private Duty Nursing and Home Health Aide Letter of Medical Necessity

Private Duty Team Fax: 888-245-2071

BACKGROUND INFORMATION

Gateway Health Member ID# _____ **Today's Date** ____/_____/____

Member Name_____ **Member's Date of Birth** __/____/____

Date of last office visit: _____/_____/_____ **Date of last hospitalization:** _____/_____/_____

Diagnoses: _____

Does the Member have other insurance? Yes ☐ **No** ☐ Primary _____ Secondary _____

REQUESTED SERVICES

Type of Request: Initial Request ☐ Annual Review ☐ Change in Shift Care Services ☐
Level of care requested: RN ☐ LPN ☐ Home Health Aide (HHA) ☐

Specify the hours to be provided in the home on School Days:

	MON	TUES	WED	THURS	FRI
Daytime Hours					

Specify the hours to be provided in the Home on Non-School Days:

	MON	TUES	WED	THURS	FRI	SAT	SUN
Daytime Hours							
Nighttime Hours							

Specify the hours to be provided in School:

	MON	TUES	WED	THURS	FRI	
School Hours						

SUPPORTING CLINICAL INFORMATION

CARE NEEDS
Enteral Feeding: Yes ☐ No ☐ Bolus Feeds: Yes ☐ No ☐ Frequency: _____ Continuous Feeds: Yes ☐ No ☐ PO Feeds: Yes ☐ No ☐
TPN: Yes ☐ No ☐ Frequency: _____ Duration: _____
Wound Care (to include dressing changes): Yes ☐ No ☐ Frequency_____
Ostomy Care: Yes ☐ No ☐ Frequency: _____

Gateway Health

CARE NEEDS (continued)

IV Catheter: Yes ☐ No ☐ Type: (e.g., PICC, Broviac, Peripheral) _____ Frequency of use: _____

Tracheostomy: Yes ☐ No ☐
How often performed per day? _____ Changed (frequency) _____
How often is suctioning performed per day? _____

Ventilator: Yes ☐ No ☐
Continuous ☐ Sleep Only ☐
Hours per day on ventilator: _____ During particular hours? _____
Weaning schedule: Yes ☐ No ☐

Respiratory Issues(s) Oxygen: Yes ☐ No ☐
Continuous: ☐ Intermittent: ☐ PRN: ☐
Pulse Ox: Yes ☐ No ☐
Suctioning: Yes ☐ No ☐ Frequency: _____

Seizures: Yes ☐ No ☐ Date of member's last seizure: ____/____/____
Average number of seizures per day: _____ Average Duration: _____
Date of last skilled intervention (VNS, Diastat, Oxygen, etc.) ____/____/____

Medication Administration: If insufficient space, attach list including route, frequency and dosage

Medication	Dose	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Durable Medical Equipment (DME) related to care:

Are Behavioral Health, MH/ID Services provided? Yes ☐ No ☐
Type of Services (e.g., TSS, wraparound services, family-based): _____
Please indicate total hours provided per day for each service: _____
Other Behavioral Health issues: _____

Assessment of member's Activities of Daily Living (ADL) functions:

	Independent	*Mod/Max Assist*	*Dependent*	*Other*
Bathing	☐	☐	☐	☐ _____
Grooming	☐	☐	☐	☐ _____
Dressing	☐	☐	☐	☐ _____
Toileting	☐	☐	☐	☐ _____
Bed Mobility	☐	☐	☐	☐ _____
Transfers	☐	☐	☐	☐ _____
Eating	☐	☐	☐	☐ _____

Gateway Health

FOR CARE PROVIDED IN SCHOOL

If the member requires any care in a SCHOOL SETTING, provide the following information, if available:

1. Are therapies performed in the home, in school, or as outpatient? _____
   If yes, what therapies are performed?
   OT ___ Hours/week; PT ____ Hours/Week; ST ____ Hours/week; Other ____ Hours/week

2. Is the school district providing 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: _____
   _____

3. School District: _____ School Name: _____ Method of Transportation: _____

4. Total hours of school attendance daily, including travel time: _____

5. Indicate the services, if any, which are required while the child is being transported to school: _____
   _____

CAREGIVER INFORMATION

(If not available, this information can be submitted separately)

	1	2
Name of Parent/Caregiver(s):	_____	_____
Relationship to Member:	_____	_____
Contact Phone Number:	_____	_____
Work Schedule (plus travel time):	_____*	_____*
School Schedule (plus travel time):	_____*	_____*

*Work verification or Registrar's Certificate will be required for each caregiver.

Other individuals living in home? Yes ☐ No ☐
(Indicate relationship to member and age) _____

PHYSICIAN INFORMATION

In the narrative field below or in a separately attached document(s), please provide any relevant additional clinical information supporting the need for the requested service or any additional information about the caregiver's ability to provide care**:**

Certification:

By signing this document, I am submitting a request for coverage of healthcare services that is, in my professional medical opinion, medically necessary for the above named patient. I have personally examined, diagnosed, and/or treated the above mentioned patient. The information contained on this request for coverage is true, accurate, and complete to the best of my knowledge.

SIGNED: **Ordering Physician (signature)** _____ NPI #_____

Office #_____

Ordering Physician (print name) _____ Fax # _____