NC MEDICAID
PRIVATE DUTY NURSING (PDN)
PHYSICIANS REQUEST FORM

NC Medicaid-3075

A. The payer for this service is: Medicaid: ☐

Requested SOC date:_____ * Complete form within 15 business days of the start of care date and submit to NC Medicaid.

1. Patient Name:_____ 2. Address: _____
3. Phone Number:_____ 4. Recipient ID #: _____
5. Date of Birth:_____ 6. Diagnosis: _____
7. Prognosis and expectations of specific disease process: _____
8. Date of last physician assessment: _____
9. Services requested and why: _____
10. Specify how many hours/days/weeks requested: _____
11. Informal caregivers' availability and training received: _____

Technology Requirements and Nursing Care Needs

12. Ventilator dependent? ☐ No ☐ Yes Type: _____
13. Hours per day on ventilator: _____
14. Oxygen? ☐ No ☐ Yes Actual liters per minute and hours per day required: _____
15. Continuous prescribed rate?_____ or adjusted daily or more often? (specify): _____
16. Maintain sats >_____% Frequent need for adjustments and interventions? _____
17. Non-ventilator dependent tracheostomy? Circle one. ☐ No ☐ Yes
18. Name of Provider Agency: _____
19. Requesting Provider #:_____ NPI: ☐ Atypical: ☐ 20. Taxonomy: _____
21. Address: _____ 22. Nine Digit Zip Code: _____
23. Does that patient have insurance in addition to Medicaid? ☐ Yes ☐ No
24. Is PDN covered by private insurance? ☐ Yes ☐ No If Yes, explain coverage: _____
25. Date of last approval period: _____
26. Current attending physician: _____
27. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____
28. Date of last weight (adults), height and weight for pediatric recipients: _____
29. Date of last examination by MD (name of MD): _____
30. Changes in recipient's condition: _____

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31. Home visit observations. Safety of environment, and caregiver information: _____

_____

_____

32. Critical incidents with the recipient (hospitalizations, falls, infections, etc.): _____

_____

_____

33. Therapies recipient is receiving (PT, OT, ST, RT, etc.): _____

_____

34. Emergency plan of care if nurse is not available; _____

_____

35. Training needs: _____

_____

_____

_____

36. Education provided, return demonstrations and identification of ongoing needs: _____

Print Physicians Name: _____

Print Physicians Address & Phone Number: _____

Physicians Signature: _____ Date:_____