



NC Medicaid-3061

NC MEDICAID
PRIVATE DUTY NURSING (PDN)

PRIOR APPROVAL REFERRAL FORM

For initial PDN requests, submit either a) this form along with a NC Medicaid-3075 or b) a physician's letter of medical necessity.

PATIENT INFORMATION

Name:
Address: Phone Number:
MID #: Medicare #: Birthdate: Sex:

RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name:
Address:
Phone Number: Relationship:

CAREGIVER INFORMATION

Name:
Address:
Phone Numbers: work home
Relationship to Recipient:
Hours/Day Available to Care for Recipient:

PHYSICIAN INFORMATION

Community Attending's Name:
Address: Phone Number:
Names and Phone Numbers of Other Physicians Ordering Care:

NURSING AGENCY INFORMATION

PDN Agency:
Address:
Nursing Contact Person: Contact's Phone Number:
PDN Provider Number:

INSURANCE INFORMATION

Insurer's Name:
Address:
Contact Person & Phone Number:
Policy or ID Number: Amount of PDN Covered by Insurance:

MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN:

Primary nursing interventions and the frequency with which these are performed at home:

Physician Orders for Daily Hours and Weeks' Duration:

Decreasing Hours:
Referred by Name/Agency:
Phone Number: