

# Private Duty Nursing Services



Requests for authorizations should be sent to:

**Mountain Pacific Quality Health, 3404 Cooney Drive, Helena MT 59602**  
**Phone: 406-443-4020, Extension 5850 or 800-262-1545, Extension 5850 Fax: 406-513-1922 or 877-428-0684**

Request for Authorization								
Member Name: Last		First		MI		Medicaid ID#:		
Street Address:				City:		State:	Zip:	
DOB:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Attends school: <input type="checkbox"/> No <input type="checkbox"/> Yes			
Primary (in home) caregiver's name:					Relationship:			
Secondary (in home) caregiver's name:					Relationship:			
Will your agency be reimbursing an employee, who is a licensed RN or LPN, that is considered part of the member's family, or household, for providing nursing services?							<input type="checkbox"/> No	<input type="checkbox"/> Yes
Agency Provider Name:					NPI:			
Agency Contact:				Phone #:		Fax #:		
Physician's name:					Phone #:			
Principal diagnosis:								
Additional Comments:								
Request for services to be provided in the home								
Number of skilled service hours requested per day:							Total	
Sun-	Mon-	Tues-	Wed-	Thur-	Fri-	Sat-		
Skilled services and treatments to be provided (frequency, estimated time/service):								
<input type="checkbox"/> Medication administration: <input type="checkbox"/> Oral <input type="checkbox"/> G-Tube <input type="checkbox"/> IV <input type="checkbox"/> IM <input type="checkbox"/> SQ								
List medications and frequency:								
<input type="checkbox"/> Trach suctioning/care								
<input type="checkbox"/> Vent care								
<input type="checkbox"/> Sterile dressing changes								
<input type="checkbox"/> Tube Feedings: <input type="checkbox"/> Continuous pump <input type="checkbox"/> Bolus								
<input type="checkbox"/> Other:								
If meds or treatments are ordered PRN, accurate records of date, time and duration of the treatments must be submitted at the end of the date span.								

Signed Doctor's orders are attached

\_\_\_\_\_  
Signature of person submitting request

\_\_\_\_\_  
Date

**All private duty nursing services must be prior authorized.**

Requests must be renewed every 90 days during the first 6 months of service, and every 6 months thereafter, or any time the condition of the child changes, resulting in a change to the amount of skilled nursing services required.