Pediatric Complex Care Assistant (PCCA) Services Prior Authorization Request

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

All PCCA services must be prior authorized. Requests must be renewed every 90 days during the first six months of service, and every six months thereafter or, anytime the condition of the child changes, resulting in a change to the identified service, frequency or time of the PCCA services.

Requests for prior authorization must be submitted to Mountain Pacific through the Mountain Pacific Provider Portal.

Member Information			
Last Name	**First Name**	**Middle Initial**	**Medicaid ID Number**

At Home Status

Is the member receiving Private Duty Nursing (PDN) at home? ☐ Yes ☐ No

- If Yes, number of received hours/day?
- Agency providing PDN is: _____

Is the member receiving Community First Choice Services/Personal Care Services? ☐ Yes ☐ No

Is the member receiving Home Health? ☐ Yes ☐ No

- If Yes, number of received hours per day or week?
- Expected length of Home Health services?
- Home Health agency is: _____

In School Status

Is the member in school? ☐ Yes ☐ No

Is the member receiving Private Duty Nursing (PDN) at school? ☐ Yes ☐ No

Provider Information		
Provider Agency Name	**Provider Agency NPI**	
Agency Contact First and Last Name	**Telephone**	**Fax**

Physician Information and Orders		
Ordering Physician Name	**Telephone Number**	**Fax Number**
Principal Diagnosis		
Additional Comments		

Request for PCCA Services	
Select the box for each service being requested. Indicate the frequency per day or per week for each service selected. PCCA services are provided where the child resides.	
☐ **Tracheostomy care**	**Frequency (per day or per week)**
☐ **Airway clearance, airway management including oxygen**	**Frequency (per day or per week)**
☐ **Enteral care and therapy**	**Frequency (per day or per week)**
☐ **Wound care**	**Frequency (per day or per week)**
☐ **Central line care or IV fluid administration**	**Frequency (per day or per week)**
☐ **Bowel care, including enema administration and ostomy care**	**Frequency (per day or per week)**
☐ **Medication administration** **Upload current list of medications when uploading this form.**	**Frequency (per day or per week)**

Physician Printed Name and Signature	
Physician Printed Name	
Physician Signature	**Date**