PDN MEMBER AUTHORIZATION FORM

Date:
Fax To: 502-585-8204
Attn: PDN
Member Information: _____

Member's Name: _____ Member's DOB: _____

Passport ID: _____ Authorization Number: _____

Provider Information

	MD INFORMATION	PDN AGENCY INFORMATION
Name		
Provider ID	N/A	
Address		
Phone		
Fax		
Contact Name		
N/A		

Clinical Information

DIAGNOSIS (INCLUDE ICD 9 CODE)	
DIAGNOSIS	**ICD 9 CODE**

Dates of Service Requesting _____ to _____

Days and Number of Hours _____

(i.e. 8 hours per day Monday – Friday and 4 hours Saturday –Sunday / 48 hours per week)

Why are PDN hours required (please circle one below):

☐ Caregiver to sleep only ☐ Caregiver to work/school only ☐ Both

This form must be faxed with:

1) 485 plan of care and narrative note for the current certification period
2) A letter of medical necessity from the md (to be dated every 6 months)
3) Caregiver work note or school note with the days and hours worked or attending school (to be dated every 6 months)
4) 1 Week of the most recent nursing notes

Also, any additional information as to why PDN is needed.