Home Care Nursing/Private Duty Nursing Request Form

MSHO and MSC+ Only

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision. Failure to provide required documentation may result in denial of request.

- Submit the following information along with this request form: Physician orders/CMS 485/OASIS.
- Complete the DHS Home Care Nursing Assessment Form (DHS-4071A) or the Home Care Nursing Assessment Form (pg 2). Here is a link to the Home Care Nursing Assessment Instructions (DHS-4071B).

Fax form and relevant clinical documentation to:
612-884-2499 or 1-866-610-7215

For questions, **call**: 612-676-3300 or
1-888-531-1493

Submit request: UCare's Secure E-mail Site
E-mail: HCM_Fax@ucare.org

Member Information

Member Name: _____
UCare ID: _____ PMI: _____ Member DOB: _____
Member Address: _____
Member City, State, Zip: _____ Member Phone: _____

Ordering Provider Information

Ordering Provider Name: _____ NPI: _____
Ordering Provider Address: _____
Ordering Provider City, State, Zip: _____
Ordering Provider Phone: _____ Fax: _____

Home Care Provider Information

Home Care Provider Name: _____ NPI: _____
Home Care Provider Address: _____
Home Care Provider City, State, Zip: _____
Home Care Provider Contact Name: _____
Home Care Provider Contact Phone: _____ Fax: _____
Home Care Provider Email: _____

Dates/Codes/Units

Home Care Rating (Home Care Nursing Service Decision Tree - DHS-4071C): EN ☐ CA/IN ☐ HL ☐ HC ☐

Based on documentation of instability and interventions needed and recorded on page 2, the member requires:

Regular HCN - Ongoing hourly nursing services to maintain or restore a person's health.

Regular HCN	Procedure Code	Units/Day
☐ LPN Regular	T1003	
☐ LPN Shared	T1003 Mod TT	
☐ RN Regular	T1002	
☐ RN Shared	T1002 Mod TT	

OR

Complex HCN - Nursing to provide life-sustaining interventions to reduce the risk of long-term injury or death.

Complex HCN	Procedure Code	Units/Day
☐ LPN Complex	T1003 Mod TG	
☐ RN Complex	T1002 Mod TG	

Service Dates Requested	Start Date: _____	End Date: _____

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Home Care Nursing Assessment

Member Name: _____ UCare Member ID#: _____

Review of Systems: Check which systems require nursing interventions. Document the nature of the intervention in the area provided and diagnosis.	**Nursing Interventions Required:** Clearly identify episodes of instability and the subsequent nursing interventions. Attach an additional sheet if needed.
☐ **Skin** Include wound or decubiti care, special treatments.	
☐ **Eyes, Ears, Nose, Throat** Include tracheostomy care – cleaning, changing, suctioning and frequency.	
☐ **Musculoskeletal** Diagnosis: _____	
☐ **Respiratory** Diagnosis:_____ ☐ **Mechanical Vent**: _____ ☐ C-Pap ☐ Bi-Pap **# Hours/day:**	
☐ **Metabolic/Endocrine** Diagnosis: _____	
☐ **Gastrointestinal** Diagnosis: _____ Include tube feeding (bolus or continuous), ostomies, bowel programs, etc.	
☐ **Neurological** Diagnosis: _____ Include observations and interventions for seizures.	
☐ **Cardiovascular** Diagnosis: _____	
☐ **Genitourinary** Diagnosis: _____ Include catheters, irrigation, etc.	
☐ **Behavioral/Mental Health** Diagnosis: _____	
☐ **Other** i.e. central lines, IV's, parenteral injections, etc.	

Does member receive personal care assistance services (PCA)? ☐ YES ☐ NO

If yes; hours per day: _____ and agency name: _____.