⁂UCare.

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:	DOB:
Address:		
City, State, Zip:		Phone:

ORDERING PROVIDER INFORMATION:	
Ordering Provider Name:	NPI (required)*:
Address:	
City, State, Zip:	
Phone:	Fax:

HOME CARE PROVIDER INFORMATION:	
Home Care Provider Name:	NPI (required)*:
Address:	
City, State, Zip:	
Contact Name:	
Contact Phone:	Fax:

DATES/CODES/UNITS:

Home Care Rating (Home Care Nursing Service Decision Tree - DHS-4071C)

Regular HCN	Procedure Code	Hours/Day	Start Date	End Date
☐ LPN Regular	T1003			
☐ LPN Shared	T1003 Mod TT			
☐ RN Regular	T1002			
☐ RN Shared	T1002 Mod TT			

OR

Complex HCN	Procedure Code	Hours/Day	Start Date	End Date
☐ LPN Complex	T1003 Mod TG			
☐ RN Complex	T1002 Mod TG			

ICD-10 Diagnosis Code: _____

ADDITIONAL INFORMATION:
Must include a current plan of care and MD order for HCN/PDN Services

Does member receive personal care assistance services (PCA)?　☐ Yes　☐ No

If Yes; Hours per day _____　Agency Name: _____