

Horizon NJ Health 1700 American Blvd. Pennington, NJ 08534 horizonNJhealth.com

Date of Request:

Horizon NJ Health Initial Private Duty Nursing (PDN) Request

Authorization Requests can be submitted online securely via NaviNet. If a request is submitted via Navinet, please ensure authorization forms are attached to the request. If you are not registered, please visit NaviNet.net and click *Sign Up*, or call NaviNet Customer Care at 1-888-482-8057.

Requirements: Clinical information and supportive documentation should consist of Letter of Medical Necessity or 485(Physician Plan of Care), Supervisor note, Nursing notes and any discharge information, if applicable. Please complete this form in its entirety in order to prevent processing delays. No request will be processed without a completed and signed form. Once the form is completed, please fax it to PDN Dept. at **1-609-583-3032**.

1. Member Data

	Member Name:	
	Member ID number:	Date of Birth:
	Phone:	Projected Discharge Date:
	Parent/Legal Guardian/Principal Care Gi	
	Care Provider in home?	
	Relationship(s) to member:	
	Care giver issues:	
	Other dependents/persons in the home an	nd age:
	Ordering Physician with contact informa	tion:
	Other agencies involved:	
2.	Requesting Agency Information Agency Name:	Provider ID#:
	Contact Name:	
	Phone #:	
•		
3.	Medical Information Required	
	Primary Diagnosis with ICD 10 Code:	
	Date Range:	
	Hours Requested per Day:	

4. Clinical Information

System/Device	Yes/No	Comments
Vent		Type and Settings:
Trach		Type and Size:
СРАР		Delivery Method:
BiPAP		Delivery Method:
Oxygen		How many liters?
		Delivery Method:
Nebulizer Treatments		Frequency:
Chest PT		Frequency:
Suctioning		Frequency:
Central Line		Location:
PICC Line		Location:
Broviac		Location:
Hep Lock		Location:
Diet		Describe:
Tube Feed		GT/GJT/NGT
Tube Feed		Continuous or Bolus
Tube Feed		Brand:
Weight		
Height		
Aspiration		
Precautions		
		Seizure Log attached: Y/N
Seizure Precautions		Last known Seizure:
Wound Care		Site:
		Order:
		How old?
Special Skin Precautions		Describer
		Describe:
Ostomy		Туре:
Incontinence Bowel/Bladder		
Training		
Mobility Problems		Describe:
Sleep Disturbance		Describe:
Communication		
Deficit		Describe:
Orientation		Alert/Awake/Oriented
Combative/Abusive		Describe:
Out of home		
Treatment		What services? Where?

Medication Information

Medication	Dose	Route	Frequency

5. Clinical Needs

Durable Medical Equipment needed with provider name and phone:

6. Physician's Certification

This is to certify that I have met with the parent/guardian and reviewed	_'s
diagnosis, medical status and prognosis, as well as alternatives to home care, and that he/she	
understands the medical needs required and his/her responsibilities for home management. I al	so
certify that is an appropriate candidate for home care.	

Physician's Signature:	Date:
Address:	Phone:

Parent/Guardian Agreement:

This is to certify that ______'s diagnosis, medical status, and prognosis have been discussed with me and I understand the care that this necessitates. Alternatives to home care and their availability have been reviewed for me. I agree to home placement and I accept the primary responsibility for this care.

Parent/Guardian Signature:	Date: