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

Date of 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.

Horizon NJ Health Private Duty Nursing (PDN) Extended Authorization Request

Please fax completed forms to PDN Dept. at **1-609-583-3032**.

Last Authorization Dates: From __________to___________

1. **Member Data**
   Member Name: ____
   Member ID number: ____________________ Date of Birth: ________________
   Phone: ______________________ Projected Discharge Date: ______________
   Parent/Legal Guardian/Principal Care Giver: _____________________________
   Care Provider in home? _______ How many? _______________________
   Relationship(s) to member: ____
   Care giver issues: ____
   Other dependents/persons in the home and age: _____________________________
   Ordering Physician with contact information: ______________________________
   Other agencies involved: ____

2. **Requesting Agency Information**
   Agency Name: _____________________ Provider ID#: ______________
   NPI#: ________________________TIN: _______________________
   Contact Name: __________________________________
   Phone #: ___________________

3. **Medical Information Required**
   Primary Diagnosis with ICD 10 Code: ___________________________________
   Other Diagnosis with ICD 10 Code: ____________________________________
   Date Range for Reauthorization: ______________________________________
   Hours Requested per Day: ____

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4. Clinical Information

System/Device	Yes/No	Comments
Vent		Type and Settings:
Trach		Type and Size:
CPAP		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 Precautions		Seizure Log attached: **Y/N** Last known Seizure:
Wound Care		Site:
		Order:
		How old?
Special Skin Precautions		Describe:
Ostomy		Type:
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	Dose	Route	Frequency

5. Clinical Needs

Durable Medical Equipment needed with provider name and phone:

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New Changes in care needs since last request:

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Form to be faxed back within **14 days** prior to present PDN authorization expiration date.
Fax to **1-609-583-3032**.