

Managed Health Services Home Nursing Medical Necessity Determination Form

1099 N. Meridian St.
Suite 400
Indianapolis, In 46204
317-684-8096(fax) 1800-464-0991 (phone)

Legend

WNL = Within Normal Limits	WFL = Within Functional Limits	MIN = Minimal Assist
UE = Upper Extremity	LE = Lower Extremity	MOD = Moderate Assist
SBA = Stand By Assist	CGA = Contact Guard Assist	MAX = Maximal Assist
PWB = Partial Weight Bearing	TWB = Total Weight Bearing	NWB = No Weight Bearing
NT = Not Tested	WC = Wheel Chair	HHA = Hand Held Assist
R = Right	L = Left	I = Independent
		WBAT = Weight Bearing As Tolerated

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DIRECTIONS: Please fax completed forms to Managed Health Services (MHS). Managed Health Services has TWO working days to respond. If you do not receive a response within TWO working days, you may call 1-800-640-991-to check on status. <i>(Please fill out form completely and print clearly when applicable)</i>			
DATE OF SUBMISSION _____			
PROVIDER DATA			
Name of Home Nursing Agency:		MHS Provider /Medicaid Provider Number:	
Street Address of Home Care Agency:			
City:		State:	Zip Code:
Contact Staff Member:		Phone Number:	Fax Number:
Does Patient currently have Home Nursing Services Approved by EDS or PCCM? (Please Circle YES NO If Yes, submit a copy of the Prior Approval received from EDS/PCCM, and how many units have been utilized up to the date that eligibility changed.		Referring Physician:	
RECIPIENT DATA:			
Member Name:		Member Date of Birth: ____/____/____	
HCFA Number:		Other Insurance:	
AGE:	Sex: M F	WEIGHT: ____lb. ____oz. HEIGHT: ____	Marital Status S M D W
CLINICAL DATA			
Primary Diagnosis:			
Secondary Diagnosis:			
Etiology:		ICD 9 Codes:	
Date of Onset: ____/____/____		Has Member had previous Home Nursing Services? YES NO	
If Yes, When & Where:			
Is Primary Care Giver(s) Employed Outside Home? Yes No		If Primary Care Giver(s) are Employed outside of Home, Please provide proof of Employment such as statement signed by Employer with Number of Hours worked per day per week	
If Yes, how many hours per day and days per week are Spent at Work? Primary Care Giver _____ Secondary Care Giver _____			
Requested Start Date of Services Being Requested: ____/____/____		Projected Length of Time Services Will Be Required: ____/____/____	

MHS CONFIDENTIALITY NOTE

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Thank You

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CLINICAL DATA (Continued)														
VITAL SIGNS ON LAST VISIT:														
DATE OF LAST VISIT OR INITIAL EVALUATION: _____														
TEMP: _____				HEART RATE: _____				RESP: _____				B/P: _____		
Does Member Require a Special Bed? YES NO							TYPE: _____							
Decubiti: YES NO					Location: _____									
Degree: _____					Treatment: _____									
PREVIOUS FUNCTIONAL ABILITY Prior TO THIS INJURY AND/OR ILLNESS:														
SELF CARE: INDEPENDENT				REQUIRED ASSISTANCE										
AMBULATION: INDEPENDENT				REQUIRED ASSISTANCE										
DEVICE: NONE CRUTCHES				CANE WALKER WC										
DISTANCE: _____														
PRESENT FUNCTIONAL STATUS:														
RANGE OF MOTION:														
RIGHT	UE	WNL	WFL	LIMITED	LEFT	UE	WNL	WFL	LIMITED					
RIGHT	LE	WNL	WFL	LIMITED	LEFT	LE	WNL	WFL	LIMITED					
STRENGTH: 5 = Strongest 1 = Weakest														
RIGHT							LEFT							
1	2	3	4	5	NT	SHOULDER	1	2	3	4	5	NT		
1	2	3	4	5	NT	ELBOW	1	2	3	4	5	NT		
1	2	3	4	5	NT	HIP	1	2	3	4	5	NT		
1	2	3	4	5	NT	KNEE	1	2	3	4	5	NT		
1	2	3	4	5	NT	ANKLE	1	2	3	4	5	NT		
MOBILITY:														
ROLLING	I	SBA	CGA	MIN	MOD	MAX								
SCOOTING	I	SBA	CGA	MIN	MOD	MAX								
SUPINE TO SIT	I	SBA	CGA	MIN	MOD	MAX								
SIT TO STAND	I	SBA	CGA	MIN	MOD	MAX								
STAND PIVOT	I	SBA	CGA	MIN	MOD	MAX								
AMBULATION:														
WBAT	PWB	%	TWB	R	L	NWB	R	L						
I	SBA	CGA	MIN	MOD	MAX									
DEVICE: NONE HHA WALKER CANE CRUTCHES DISTANCE: _____														
WHEELCHAIR:														
TYPE: _____							POSITIONING: _____							
PROPULSION: _____														
MANAGEMENT OF PARTS: FOOTRESTS _____ ARMRESTS _____ BRAKES _____														

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CASTED: YES NO	
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CLINICAL DATA (Continued)		
Does Patient have the Following?		
1. Pacemaker	8. G-Tube	
2. Chest Tube	9. Steinman Pins	
3. Halo Traction	10. S/P Catheter	
4. Crutchfield Tongs	11. Indwelling Catheter	
5. J-Tube	12. Nasogastric Tube	
6. Orthosis	13. Prosthesis- (please specify): _____	
7. Exdwelling Urinary Catheter	14. Other Not Listed _____	
THERAPY		
DOES PATIENT REQUIRE THERAPY SERVICES? Yes No If yes please attach a Functional Information Measure Form		
RECOMMENDED THERAPY	HOURS PER DAY	DAYS PER WEEK
PT	1 2 3 4 5	1 2 3 4 5 6 7
OT	1 2 3 4 5	1 2 3 4 5 6 7
ST	1 2 3 4 5	1 2 3 4 5 6 7
RT	1 2 3 4 5	1 2 3 4 5 6 7
PSYCH	1 2 3 4 5	1 2 3 4 5 6 7
OTHER	1 2 3 4 5	1 2 3 4 5 6 7
PLEASE SPECIFY: _____		
SHORT TERM GOALS:		TARGET DATES:
1.		
2.		
3.		
4.		
5.		
LONG TERM GOALS:		TARGET DATES:
1.		
2.		
3.		
4.		
ROUTINE MEDICATIONS: (Please Attach Separate Paper If Necessary)		

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Please Complete Entire Form = If Certain Areas Do Not Apply please Write N/A

Please Attach This Form to the MHS Prior Approval Form when Submitting Request.

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