Private Duty Nursing School Based Services

Requests for authorizations should be sent to Mountain Pacific via the Qualitrac Portal at https://mpqhf.org/.

Mountain Pacific:
560 N Park Ave Ste 200 Phone: (800) 219-7035
Helena Mt 59601 Fax: (406) 513-1922

Request For Authorization				
All private duty nursing services must be prior authorized. Requests must be renewed every 90 days during the first 6 months of service, and every 6 months thereafter, or any time the condition of the child changes, resulting in a change to the amount of skilled nursing services required.				
Note: Private Duty Nursing Home-Based Services				
Prior authorization for **home-based private duty nursing hours requires a separate completed form** to be submitted and a separate prior authorization. The form can be found on the Montana Medicaid Provider website (medicaidprovider.mt.gov) in the Forms section.				
Member Information				
Member Name	Last	First	Middle	Medicaid ID #
Member Physical Address	City	State	ZIP Code	
Member Date of Birth	Age	Sex ☐ Male ☐ Female		
Primary (In Home) Caregiver's Name	Relationship			
Secondary (In Home) Caregiver's Name	Relationship			
Will your agency be reimbursing an employee, who is a licensed RN or LPN, that is considered part of the member's family, or household, for providing nursing services?	☐ Yes ☐ No			
Member's Principal Diagnosis				

Agency Information			
School/Provider Name			Relationship
Agency Contact			Relationship
Physician's Name			
NPI			
Phone Number		Fax Number	

Request for Services to be Provided in School					
Number of skilled units requested per day (1 unit equals 15 minutes)					
☐ Monday	☐ Tuesday	☐ Wednesday	☐Thursday	☐ Friday	Total
____ # of Units	____ # of Units	____ # of Units	____ # of Units	____ # of Units	_____ # of Units
Date School Year Starts	Date School Year Ends		Summer School Date	Person Administering Medication	Title and Position

Skilled services and treatments to be provided (frequency, estimated time/service)	
☐ Trach suctioning/care	
☐ Vent Care	
☐ Sterile dressing changes	
☐ Tube Feedings	
☐ Continuous Pump	
☐ Bolus	
☐ Other, please describe	

List medication, frequency, and route of administration: (Additional page is provided if more room is needed)	
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Care Plan Goals
Short Term Goals of Care
Long Term Goals of Care

Additional Provider Comments

☐ Check if the signed Doctor's orders are attached

Signature of person submitting PDN request Date