Private Duty Nursing Services for Agencies

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
Helena Mt 59601
Phone: (800) 219-7035
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: School-based Private Duty Nursing
Prior authorization for **school-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 in	Medicaid ID #

Member Physical Address	City	State	ZIP Code

Member Date of Birth	Age	Sex	Attends School
		☐ Male ☐Female	☐ Yes ☐ No

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?	☐ No ☐ Yes

Member's Principal Diagnosis	

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

Additional Provider Comments

Request for Services to be Provided in Home						
Number of skilled units requested per day (1 unit equals 15 minutes)						
☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
___ # of Units	___ # of Units	___ # of Units	___ # of Units	___ # of Units	___ # of Units	___ # of Units
Total # Units:_____						

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 Comments

☐ Check if the signed Doctor's orders are attached

Signature of person submitting PDN request

Date