

**Michigan Department of Community Health
Completion Instructions for MSA-0732
Private Duty Nursing Prior Authorization – Request for Services**

The MSA-0732 form (page 2) must be submitted every time services are requested, i.e., before services can begin and for each specified authorization period thereafter, no less than 15 days prior to the end of the current authorization period.

MDCH requests that the MSA-0732 be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDCH website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms.

This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage **with the exception of those enrolled in the Children’s Waiver or the Habilitation Supports Waiver**. Private Duty Nursing is not a benefit under Children’s Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid. A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician’s staff person. When this is the case, the person submitting the request must do so in consultation with the PDN who will be assuming responsibility for the care of the beneficiary. If services are being requested for more than one beneficiary in the home, a separate form must be completed for each beneficiary.

Refer to the Medicaid Provider Manual, Private Duty Nursing Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDCH use only.
2	Check specific box as to whether this is an initial or renewal request. If a renewal, check the INCREASE HOURS or DECREASE HOURS box only if this request demonstrates an increase or decrease in hours from the previous authorization period.
3 - 7	PDN provider information. Provide complete agency name, or name of individual (last, first, and middle initial). Designate whether RN or LPN. Include NPI number, phone number, address, and fax number.
8 - 14	Beneficiary information. Provide complete name and birth date (month, day, and year); sex, mihealth card number, complete address, county, and primary diagnosis using the appropriate ICD-9-CM code only.
15 - 18	Other insurance information if applicable, including name of company and beneficiary’s group/policy and certificate/contract numbers.
19 - 25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26 - 30	Ordering physician information. Provide complete name (including MD or DO); NPI number, phone number, address, and fax number.
31 - 35	Description of the service(s) to be provided (i.e., RN, LPN), procedure code(s) (<i>S9123 and/or S9124, depending on whether an RN, LPN or both will be providing the services -- include modifier (TT) if appropriate</i>), and the number of total hours per month required to provide the service(s) with a start date and end date, if known.
36 - 40 43 - 49	Home environment information, including number of siblings residing in the home (include step and foster child(ren) if applicable) and if they receive PDN. Provide child’s name and mihealth card number if receiving PDN. Also provide the number of other individuals in the home requiring care (e.g., elderly parent, grandparent, disabled spouse, sibling), name(s) and number of caregivers for the beneficiary for whom services are being requested, and whether the caregiver(s) either work and/or attend school outside of the home. If so, how many hours are spent working and/or attending school. (Additional pages may be required.)
41 - 42	Current school information if child is or will be attending school during the authorization period when PDN services are being provided. Include number of hours per day and per week, including travel time.
50 - 56	If more than one PDN or PDN agency is involved, their name(s), phone number(s), fax number(s), and which PDN will be managing the care plan (i.e., the provider named in items 2 – 6, or the provider named in this space).
57	The signature certifies that: <ul style="list-style-type: none"> o the individual requesting the services understands the necessity for prior authorization for the services; and o the information provided on this form is accurate and complete.
58 - 60	MDCH Use Only

Form Submission

The completed MSA-0732 (page 2) and required documentation must be mailed or faxed to:

Michigan Department of Community Health **Fax:** (517) 241-7813
Program Review Division
P.O. Box 30170
Lansing, MI 48909

Questions should be directed to MDCH - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

Michigan Department of Community Health
PRIVATE DUTY NURSING
PRIOR AUTHORIZATION – REQUEST FOR SERVICES

1. PRIOR AUTHORIZATION NUMBER (MDCH USE ONLY)

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

2. INDICATE IF THIS REQUEST IS: <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL <input type="checkbox"/> INCREASE HOURS <input type="checkbox"/> DECREASE HOURS					
3. PROVIDER'S NAME (AGENCY NAME, OR INDIVIDUAL'S NAME (IF INDEPENDENT RN/LPN))		4. NPI NUMBER		5. PHONE NUMBER	
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				7. FAX NUMBER	
8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		9. SEX <input type="checkbox"/> M <input type="checkbox"/> F	10. BIRTH DATE	11. MIHEALTH CARD NUMBER	
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)		13. COUNTY		14. PRIMARY DIAGNOSIS (ICD-9-CM CODE)	
15. OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	16. HEALTH INSURANCE COMPANY NAME		17. GROUP / POLICY NUMBER	18. CERTIFICATE / CONTRACT NUMBER	
19. IS BENEFICIARY CURRENTLY HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER, DISCHARGE PLANNER BELOW.			ANTICIPATED DISCHARGE DATE:		
20. HOSPITAL NAME		21. HOSPITAL ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)		22. PHONE NUMBER	
23. NAME OF DISCHARGE PLANNER		24. DISCHARGE PLANNER'S PHONE NUMBER		25. DISCHARGE PLANNER'S FAX NUMBER	
26. ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL, MD OR DO)		27. NPI NUMBER		28. PHONE NUMBER	
29. PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				30. FAX NUMBER	
31. DESCRIPTION OF SERVICE		32. PROCEDURE CODE(S)	33. HOURS PER MONTH	34. START DATE 35. END DATE	
36. NUMBER OF SIBLINGS	37. DOES ANYONE ELSE RECEIVE PDN SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO	38. IF YES, PROVIDE CHILD'S NAME RECEIVING PDN SERVICES		39. CHILD'S MIHEALTH CARD NUMBER	
40. NUMBER OF OTHER INDIVIDUALS IN HOME REQUIRING CARE		41. IS THE BENEFICIARY CURRENTLY IN SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO		42. IF YES, HOW MANY HOURS? _____ PER DAY _____ PER WEEK (INCLUDE TRAVEL TIME)	
43. NUMBER OF CAREGIVERS	44. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY		45. WORK OR ATTEND SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	46. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL	
	47. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY		48. WORK OR ATTEND SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	49. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL	
50. IS MORE THAN ONE PERSON/AGENCY INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	51. NAME OF OTHER PERSON/AGENCY		52. NPI NUMBER	53. PHONE NUMBER	
			54. FAX NUMBER		
55. WHO WILL BE MANAGING THE PDN CARE PLAN?			56. PHONE NUMBER (IF DIFFERENT THAN #5 ABOVE)		
<p>57. CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR AUTHORIZATION FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR AUTHORIZATION AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF AUTHORIZED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.</p> <p>PROVIDER CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.</p>					
PROVIDER'S SIGNATURE			DATE		
MDCH USE ONLY					
58. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>		59. CONSULTANT REMARKS			
60.					
CONSULTANT SIGNATURE			DATE		