Commonwealth of Massachusetts
Executive Office of Health and Human Services

Request and Justification for Continuous Skilled Nursing Services

I. General Information

Personal Information

Member's Name: _____

Member's MassHealth ID Number: _____

Telephone Number: (_____) _____

Other Insurance Information

MassHealth is the payer of last resort. The provider should use diligent efforts to obtain coverage from other insurance sources.

Private Insurance Carrier: _____

Policyholder's Name: _____

Policy Number: _____

Group Number: _____

Why is this service not covered under this insurance? _____

Has this insurance carrier changed since the last prior-authorization request? ☐ Yes ☐ No

Household Information

Primary Caregivers: _____ Relationship: _____

_____ Relationship: _____

Has there been any change in the member's status that requires additional training of the primary caregivers? If so, please be specific.

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Are there other members in the home who also receive continuous skilled nursing services? If so, list the names of the members, the number of hours per calendar week, and the home health agency involved.

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II. Patient Assessment

Date of Birth: _____ Weight: _____ Height: _____

Primary Medical Diagnosis: _____

Secondary Medical Diagnoses: _____

Describe in detail the member's developmental status and ability to perform activities of daily living.

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III. Plan of Care

Provide a plan of care based on a 24-hour-a-day, seven-day calendar week. List only skilled nursing interventions that require a licensed nurse. Indicate a specific frequency (not "prn," "see attached," or "as needed").

Skilled Intervention	Frequency per Day

Total number of hours requested: _____

IV. Medications

List all prescription and nonprescription medications that the member takes. **You must document the actual use of PRN medications.** Attach a separate page if you need more space to document all medications.

Medication, Dosage, and Route Administered	Frequency/Actual Use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

V. Equipment/Supplies

For all items listed below, indicate if they are required in the member's care. If equipment or supplies are required, **you must indicate the specific type of equipment or supply used**.

Equipment	Yes	No	Frequency of Use
Tracheostomy Tubes	☐	☐	_____
Suction Machine	☐	☐	_____
Ventilator (type): _____	☐	☐	_____
Mist	☐	☐	_____
Oxygen	☐	☐	_____
Ambu Bag	☐	☐	_____
Nebulizer	☐	☐	_____
Gastrostomy Tubes	☐	☐	_____
Pump/Supplies	☐	☐	_____
Nasogastric Tubes	☐	☐	_____
Oxymeter	☐	☐	_____
Cardiac/Apnea Monitor	☐	☐	_____
Catheter (type): _____	☐	☐	_____
Ostomy Supplies	☐	☐	_____
I.V. Equipment (type): _____	☐	☐	_____

VI. Nursing Progress and Summary Notes

If applicable, include an updated summary of the past prior-authorization period. Document any change in the member's medical status, including inpatient and/or outpatient hospital visits, frequency of illnesses, changes in plan of care, and calls or visits to the member's physician.

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VII. Health-Related Services Currently Provided to the Member

Check all services used by the member. Indicate the frequency and payer.

Service	Yes	No	Frequency and Payer
Physical Therapy	☐	☐	_____
Occupational Therapy	☐	☐	_____
Speech/Language Therapy	☐	☐	_____
Intermittent Skilled Nursing Visits	☐	☐	_____
Home Health Aide	☐	☐	_____
Personal Care Attendant	☐	☐	_____
Adult Day Health	☐	☐	_____
Hospice	☐	☐	_____
Other: _____	☐	☐	_____

If the member has a third-party insurance, indicate the reason the primary insurer is not covering the services listed in Section VI that are used by the member. List the name and telephone number of the insurance case manager.

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VIII. Services Provided by Other Agencies

If applicable, list services (including respite and case management) that are provided by other sources such as the Massachusetts Commission for the Blind, the Department of Public Health, the Department of Social Services, the Department of Education, the Department of Mental Health, the Department of Mental Retardation, and an early intervention program. Indicate the frequency of service and the name and telephone number of the case manager.

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IX. Request for Continuous Skilled Nursing

Total number of hours per calendar week requested: _____

Current Prior Authorization Number (if applicable): _____ Expiration Date: _____

Number of hours authorized per week: _____

X. Names and Signatures

Home Health Agency Name: _____

Address: _____

Telephone Number: _____

Nurse from Home Health Agency or Independent Nurse

Name: _____ Telephone No.: (_____) _____

Signature: _____ Date: _____

Physician's Name: _____ Telephone No.: (_____) _____

Signature: _____ Date: _____

Primary Caregiver's Name (optional):

Signature: _____ Date: _____