



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 SPECIAL HEALTH CARE NEEDS – HEALTHY CHILDREN AND YOUTH (HCY)
HCY CONFIRMATION OF VERBAL SERVICE AUTHORIZATION

PROVIDER NAME	ATTENTION
PROVIDER FAX NO.	PROVIDER TELEPHONE NO.

AUTHORIZING SERVICE COORDINATOR	FACILITATOR	
PHONE NO.	FAX NO.	DATE

PARTICIPANT NAME (LAST, FIRST, MI)	DCN
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SERVICES

The following services have been verbally approved by the Special Health Care Needs Service Coordinator:

<input type="checkbox"/> Private Duty Nursing (PDN)	<input type="checkbox"/> Personal Care Aide	<input type="checkbox"/> Skilled Nursing Visits
<input type="checkbox"/> PDN may be provided outside the home during normal life activities.	<input type="checkbox"/> Advanced Personal Care	<input type="checkbox"/> Case Management
<input type="checkbox"/> PDN may be provided during travel outside the home overnight as specified below.	<input type="checkbox"/> Authorized RN Visit	

VISITS/HOURS AUTHORIZED	EFFECTIVE DATE
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Services to be delivered as authorized. Orders for discipline, amount, and frequency on the applicable form(s) as required in the MO HealthNet Provider Manual must match this authorization.

TERMS AND CONDITIONS

Any variation to these services must be approved prior to initiation of changes, which includes but is not limited to:
 Increase or decrease in authorized hours/visits
 Change of residence/family status
 Change in Medical Status or child admitted to hospital, etc.

This is not an official prior authorization. The plan of care, physician orders, and Prior Authorization form must be submitted to Special Health Care Needs within 90 days for services to be approved for payment. SHCN will complete the Prior Authorization form for PDN Services.

Please sign, date and return to the fax number indicated above. Questions and concerns may be directed to the Service Coordinator or Facilitator.

STATEMENT OF UNDERSTANDING

I acknowledge that my signature indicates understanding and agreement with authorized services, terms and conditions above.

SIGNATURE	DATE
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