Provider Statement of Need

STAR+PLUS and STAR+PLUS MMP

The Provider Statement of Need (PSON) is required prior to the authorization of Habilitation (HAB) or Personal Assistance Services (PAS). These are ***non-technical attendant services*** authorized for eligible members who have a medical condition resulting in a functional limitation in performing personal care. The attendants who help members with activities of daily living, such as bathing, grooming and meal preparation, are trained and supervised by non-medical personnel.

The PSON form below must be signed by a Physician, Nurse Practitioner (NP) or Physician Assistant (PA) who has examined the member and reviewed the medical record within the last 12 months.

Instructions: Please completely fill out the form below, and obtain a signature by the Physician, NP or PA in the Provider Signature line. Once completed, return the form by fax to **1-866-703-0502**, or electronically with an Adobe e-Signature to SHP.Intake@SuperiorHealthPlan.com.

For any questions, concerns or to discuss this member's care, please call Superior at **1-877-277-9772** (STAR+PLUS) or **1-855-772-7075** (STAR+PLUS Medicare-Medicaid Plan [MMP]).

Member Information: ☐ Initial request for services ☐ Reassessment ☐ Change in Condition (CIC)

Member Name:	
Medicaid Member ID:	Member Date of Birth:

Section A. Has this patient been examined within the last 12 months?

YES	NO
☐ Yes, I hereby certify that this individual has been examined within the past 12 months. **If certifying "Yes", please complete Section B and Section C.**	☐ No, I am unable to certify that this individual has been examined within the past 12 months. **If certifying "No", please bypass Section B and complete Section C.**

Section B. Does this patient need the non-technical attendant services described above?

YES	NO
A diagnosis of only mental illness, intellectual disability, or both, does not meet the criteria for medical need. The individual is not eligible if there is no other medical diagnosis. ☐ Yes, I hereby certify that this individual has a medical need resulting in one or more functional limitations, as indicated below. **If the medical need is temporary, I anticipate the need will end on:** ___ ___ ____ ***(If the medical need is not temporary, this line may be left blank.)***	☐ No, I am unable to certify that this individual has a medical need resulting in one or more functional limitations. **If certifying "No", please bypass functional limitations and complete Section C.**

If certifying "Yes", please check all functional limitations related to the member's medical diagnoses:

☐ Bedfast	☐ Behavior/Emotional Problems	☐ Blackouts	☐ Chairbound
☐ Cognitive Impairment	☐ Contractures	☐ Difficulty Swallowing	☐ Dizziness
☐ Falls Easily	☐ General Weakness	☐ Hearing Impairment	☐ Incontinence
☐ Limited Dexterity	☐ Limited Range of Motion	☐ Nausea	☐ Numbness
☐ Pain	☐ Paralysis	☐ Shortness of Breath	☐ Spasticity
☐ Tremors	☐ Unable to Stand for Long	☐ Vision Impairment	☐ Other:

Medical Diagnosis(es)	Corresponding ICD-10 Code(s)

Section C. Provider Information:

Provider Signature: X _____ **Date:** _____

Provider's Printed Name:	☐ MD ☐ NP	☐ DO ☐ PA	License or Individual NPI Number:	State:	Military or VA: ☐ Yes
Provider's Address:	Provider's Phone Number:		Provider's Fax Number:		