superior healthplan
5900 E. Ben White Blvd.
Austin, TX 78741

Provider Statement of Need

The Provider Statement of Need (PSON) is required prior to the initial assessment for Personal Assistance Services (PAS), Personal Care Services (PCS) or Habilitation (HAB). The PSON must be obtained from a Medicaid-enrolled physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) practitioner who has examined the member and reviewed the medical record within the last 12 months. The practitioner is also required to sign the PSON no more than 90 calendar days prior to the date of the request for services.

Instructions: Please fax the completed form to 1-866-703-0502 within five (5) business days. For any questions, concerns or need to discuss this member's care, please call the Superior HealthPlan Service Coordination team at 1-877-277-9772.

Provider Statement of Need (To be completed by the Physician, APRN or PA)

Member Information:

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

Please check all functional limitations related to the member's medical diagnoses:

☐ Shortness of breath	☐ Unable to stand for long	☐ Limited range of motion	☐ Cognitive impairment	☐ Behavioral/emotional problems
☐ Dizziness	☐ Difficulty swallowing	☐ Falls easily	☐ Paralysis	☐ Incontinence
☐ Pain	☐ Limited dexterity	☐ Spasticity	☐ Nausea	☐ Contractures
☐ Blackouts	☐ General weakness	☐ Tremors	☐ Numbness	☐ Vision impairment
☐ Limited mobility	☐ Hearing impairment	☐ Other: _____		

Please check only <u>one</u>:

☐ Yes, I hereby certify that:

- this individual has been examined within the past 12 months; **<u>and</u>**
- this individual has a medical need resulting in one or more functional limitations, as indicated above.

If the medical need is temporary, I anticipate the need will end on this date: _____
(If the medical need is not temporary, this line may be left blank.)

☐ No, I am unable to certify that this individual has been examined by me within the past 12 months **<u>and</u>** has a medical need resulting in one or more functional limitations.

Practitioner's Signature:	
Date of Signature:	
Practitioner Name and Credentials:	
Practitioner Telephone Number:	