# Provider Statement of Need - STAR+PLUS and MMP

The Provider Statement of Need (PSON) is required prior to the authorization of Personal Assistance Services (PAS), or Habilitation (HAB). These are ***non-technical attendant services*** authorized for eligible individuals who have a medical condition resulting in a functional limitation in performing personal care. Attendants help individuals with activities of daily living, such as bathing, grooming and meal preparation. Attendants 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. Obtain a signature by the Physician, NP or PA in the Provider Signature line and 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 MMP).

**Member Information:** ☐ Initial request for services ☐ Reassessment

| | |
|---|---|
| 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.<br><br>**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.<br><br>**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 |
|---|---|
| ☐ Yes, I hereby certify that this individual has a medical need resulting in one or more functional limitations, as indicated below.<br><br>If the medical need is temporary, I anticipate the need will end on this date: _____<br>*(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.<br><br>**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 | ☐ Behavioral/emotional problems | ☐ Blackouts | ☐ Chair bound | ☐ Cognitive impairment |
| ☐ Contractures | ☐ Difficulty swallowing | ☐ Dizziness | ☐ Falls Easily | ☐ General weakness |
| ☐ Hearing impairment | ☐ Incontinence | ☐ Limited dexterity | ☐ Limited mobility | ☐ Limited range of motion |
| ☐ Nausea | ☐ Numbness | ☐ Pain | ☐ Paralysis | ☐ Shortness of breath |
| ☐ Spasticity | ☐ Tremors | ☐ Unable to stand for long | ☐ Vision impairment | ☐ Other: _____ |

**Section C.**

| Provider Printed Name | Provider Signature | ☐ MD ☐ DO ☐ NP ☐PA Credentials | Date |
|---|---|---|---|
| Provider Phone Number | Provider Fax Number | | |