# 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

| 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.<br>☐ Yes, I hereby certify that this individual has a medical need resulting in one or more functional limitations, as indicated below.<br>**If the medical need is temporary, I anticipate the need will end on: ___/___/____**<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>**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: | | |