

Provider Statement of Need

STAR Kids and STAR Health



The Provider Statement of Need (PSON) is required prior to the authorization of Personal Care Services (PCS) or Habilitation (HAB). These are **non-technical attendant services** authorized for eligible members who have a medical or behavioral condition resulting in a functional physical, cognitive or behavioral 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 **1-844-433-2074** (STAR Kids) or **1-866-912-6283** (STAR Health).

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
<input type="checkbox"/> 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.	<input type="checkbox"/> 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
<input type="checkbox"/> Yes, I hereby certify that this individual has a medical or behavioral diagnosis resulting in one or more physical, cognitive or behavioral 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.)	<input type="checkbox"/> No, I am unable to certify that this individual has a medical/behavioral need resulting in one or more physical, cognitive or behavioral limitations. If certifying "No", please bypass functional limitations and complete Section C.

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

<input type="checkbox"/> Bed-Fast or Chair-Bound	<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Contractures/Spasticity	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Impairment of Executive	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Memory Impairment
<input type="checkbox"/> Paralysis/Limited Mobility or ROM	<input type="checkbox"/> Recurrent Aspiration	<input type="checkbox"/> Repetitive Behaviors	<input type="checkbox"/> Requires Special Diet
<input type="checkbox"/> Resistance to Assistance	<input type="checkbox"/> Seizures/Blackouts	<input type="checkbox"/> Sensory Impairments	<input type="checkbox"/> Verbal/Physical Aggression
<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Wandering Elopement	<input type="checkbox"/> Weakness/Tremors	<input type="checkbox"/> Other:

Medical Diagnosis(es)

Corresponding ICD-10 Code(s)

Section C. Provider Information:

Provider Signature: <u>X</u>		Date: _____	
Provider's Printed Name:	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	License or Individual NPI Number:	State: _____ Military or VA: <input type="checkbox"/> Yes
Provider's Address:	Provider's Phone Number:	Provider's Fax Number:	