

Provider Statement of Need

Wellcare By Superior HealthPlan (Dual Align)



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 us at [1-877-277-9772](tel:1-877-277-9772).

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

☐ 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

☐ 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

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

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