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
☐ 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
☐ 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.)***	☐ 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:

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