

**Instructions for Completing the HealthSystems of Mississippi Medicaid  
Private Duty Nursing Plan of Care Form**

**Section I Beneficiary Information**

1. **Beneficiary Name** - Enter the beneficiary's last and first name as it appears on the MS Medicaid ID card.
2. **Beneficiary Medicaid #** - Enter the beneficiary's number that appears on the MS Medicaid ID card.
3. **Date of Birth** - Enter the month, date, and year of the beneficiary's birth. (Use two-digit numbers)
4. **Sex** - Indicate the sex of the patient.
5. **Age** - Enter the age of the beneficiary at the time service is to be rendered.
6. **Beneficiary Address** - Enter the beneficiary's street address or post office box.
7. **City/State/Zip** - Enter the beneficiary's city, state and zip code.
8. **Responsible Party** - Enter the name of the responsible family member. If it is the beneficiary, enter "self".

**Section II Provider Information**

1. **Nursing Agency** - Enter the name of the agency who will provide the care.
2. **Mississippi Medicaid Number** - Enter the agency's MS Medicaid number ID.
3. **Nursing Agency Contact Person** - Enter the name of the individual who is the primary contact at the Nursing Agency.
4. **Nursing Agency Address** - Enter the nursing agency's mailing address or post office box.
5. **City/State/Zip** - Enter the nursing agency's city, state and zip code.
6. **Nursing Agency Telephone** - Enter the telephone number of the nursing agency including area code.

**Section III Request Information**

1. **Request Date** - Record the date of the request.
2. **Requested By** - Indicate whether the physician or agency made the request.
3. **Requester's Name** - Enter the name of the individual requesting the review.
4. **Requester's Tel #** - Enter the telephone number of the requester including area code.
5. **Physician Name** - Enter the name of the physician rendering the service.
6. **Physician MS Medicaid #** - Enter the physician's Mississippi Medicaid provider number.

**Section IV Medical Information**

1. **Planned Service Date** - Enter the proposed service date.
2. **Diagnoses/ICD-9-CM Codes** - Enter the beneficiary's primary diagnosis and secondary diagnoses, if applicable and enter the ICD-9-CM codes that correspond with the diagnoses.
3. **Treatment Plan/Physician Orders** - List all planned treatment including physicians' orders, as it relates to the need of nursing care. The physician must sign and date this section.
4. **Estimated length of services** - Enter the anticipated length of time for services needed.
5. **Home care services** - Indicate what types of home care services will be provided.
6. **Current care givers** - List persons caring for the patient at this time and the care being rendered.
7. **Why is Private Duty Nursing Necessary?** - Provide an explanation of the necessity of Private Duty Nursing including the reasons why a RN or LPN skills are needed.
8. **What are your expectations of Medicaid?** - Explain what you expect from the Medicaid Program.
9. **Training to Family Members** - Explain what type of training will be provided to family members.
10. **Plans if benefits are exhausted** - Explain what plans are being made by the family, after benefits are exhausted.