

Prior Approval for Private Duty Nursing

Paper Form
(eMedNY 361502)



**Department
of Health**

**Medicaid
Program**

AGENDA

- **eMedNY Website – Private Duty Nursing Resources**
- **Prior Approval – General Information**
- **Prior Approval Form (eMedNY 361502)**
- **Important Reminders**
- **Reference and Contact Information**

Private Duty Nursing Resources

eMedNY Website – www.emedny.org



The header banner features the eMedNY logo on the left. On the right, there are navigation links: [home](#), [self help](#), [glossary](#), and [site map](#). Below these is a search bar with the text "ENHANCED BY Google" and a magnifying glass icon. A row of nine blue buttons contains the following text: "What's New", "Information", "Provider Enrollment", "Provider Manuals", "Provider Outreach and Training", "Contacts", "eMedNY HIPAA Support", "eMedNY Tools Center", and "PTAR".



A banner for the "PROVIDER ENROLLMENT PORTAL" with the text "NEW! For Practitioners ONLY" and "ENROLL TODAY!". The background shows a hand holding a stethoscope and a doctor's hands using a tablet.



A large banner featuring the Statue of Liberty and a city skyline. The text reads "welcome to eMedNY".



NEW MEDICARE CARDS



MEDICAID MANAGED CARE NETWORK



PTAR
click here for more information



REVALIDATION
click here for more information



Are you compliant with NYSDOH EFT Requirement?



Login ePACES

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Provider Enrollment Portal



Web Portal

[Web Portal Information](#)



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Wage Parity



Electronic Visit Verification (EVV)

Private Duty Nursing Resources

PDN Provider Manual



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NEW! For Practitioners ONLY
PROVIDER ENROLLMENT PORTAL
ENROLL TODAY!



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NEW MEDICARE CARDS **MEDICAID MANAGED CARE NETWORK** **PTAR** **REVALIDATION**
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Private Duty Nursing Resources

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Provider Manuals

Welcome! Your Provider Manual to the New York Medicaid Program offers you a wealth of information about Medicaid, as well as specific instructions on how to submit a claim for rendered services.

[Information for All Providers](#) gives you pertinent policy and resource information!

Click on your provider manual below, and read about specific rules governing the provision of your care and service to Medicaid recipients. This section also contains billing instructions, as well as pertinent procedure codes and fee schedules.

Click on the link to the [Department of Health's Medicaid Update website](#). This monthly publication is mailed to active providers, and informs providers of up-to-date changes in the Medicaid Program. This website has an index that makes finding relevant articles an easy task!

Your provider manual, along with recent Medicaid Update articles, will act as an effective guide to your participation in Medicaid.

SELECT A PROVIDER MANUAL



[Physician](#)



[Private Duty Nursing](#)



[Rehabilitation Services](#)



[Podiatry](#)





[Radiology Prior Approval](#)



[Residential Health](#)

Adobe Reader is required to view documents.



 **MEVS and Supplemental Documentation**

Medicaid Eligibility Verification System (MEVS) Reference Material

The following information is a list of MEVS resources, including quick reference guides and the full manual.

- [MEVS/DVS Provider Manual](#)
- [MEVS Quick Reference Guides](#)
- [Choosing which MEVS method is right for you](#)

Supplemental Documentation

The following information is not part of your provider

Private Duty Nursing Resources

PDN Policy Guidelines


[Provider Manuals](#) > Private Duty Nursing Manual



Private Duty Nursing Manual

MANUAL CONTENTS

Information for All Providers


 [Policy Guidelines](#)

 [Fee Schedule](#)

 [Procedure Codes](#)

 [Provider Training Videos](#)

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 **Billing Guidelines**

 [Private Duty Nursing Billing Guidelines](#)

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 [General Remittance Guidelines](#)

 [Prior Approval Guidelines](#)

 [Prior Approval Business Location Chart](#)

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MOST RECENT COMMUNICATION

[Effective April 1, 2022, the New York State Fee-for-Service \(FFS\) Medicaid Private Duty Nursing \(PDN\) Medically Fragile Children's Program transitioned to the Medically Fragile Children and Adult \(MFCA\) Program - April 15, 2022 \(PDF 184KB\)](#)

[NYS Department of Health Rules and Regulations, Title 10](#)

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Private Duty Nursing Resources

PDN Prior Approval Requirements

PDN Manual

eMedNY > Private Duty Nursing Provider Policy



Table of Contents

1.0	Document Control Properties.....	5
2.0	Definitions.....	5
3.0	Overview of Private Duty Nursing.....	7
3.1	Overview	7
3.2	Intention.....	7
3.3	Family Responsibilities.....	7
4.0	Written Order Required.....	7
4.1	Maintain Documentation.....	7
4.2	Orders.....	7
5.0	Physician Plan of Care	7
5.1	Skilled Nursing Tasks.....	7
6.0	Prior Approval Requirements	9
6.1	Documentation Chart.....	9
6.2	Additional Information.....	12
6.3	Determination in Writing.....	12
6.4	Requests.....	12
6.5	ePACES	12

Private Duty Nursing Resources

PDN Prior Approval Requirements

6.0 Prior Approval Requirements

6.1 Documentation Chart

Prior approval for all PDN services is required before the start of providing services and the request must be submitted by a Medicaid enrolled PDN provider. There are two categories of prior approvals: New Case and Renewal/Reevaluation prior approvals. Prior approval requests are reviewed in the order in which they are received by the Department. It is the provider's responsibility to obtain all necessary paperwork and submit those requests prior to the start of providing services.

The following chart summarizes the documentation requirements for each approval interval. Requirements needing additional explanation will be discussed in more detail in other sections of the manual.

All required documentation must be dated within 6 months of the PA start date.

Information Required	New Cases	Every 6 Months	Every 12 Months
Physician's Order for Nursing Services, including: <ul style="list-style-type: none">- RN or LPN level of care- Statement justifying RN level of care (annually, if applicable)- Number of PDN hours requested (per day or per week) and distribution of hours (daytime, nighttime, flexible use hours) See section 6.8 for more information	✓	✓	✓
Physician Plan of Care/Skilled Nursing Tasks: <ul style="list-style-type: none">- Documentation of the skilled nursing needs and physician plan of care for the member. See Section 5.1 for detailed requirements	✓	✓	✓

Private Duty Nursing Resources

PDN Fee Schedule



Private Duty Nursing Manual



MANUAL CONTENTS

Information for All Providers



[Policy Guidelines](#)



[Fee Schedule](#)



[Procedure Codes](#)



[Provider Training Videos](#)



[PDN Slide Deck from September 15, 2020 Webinar](#)



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[Prior Approval Guidelines](#)



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PDN Procedure Codes




Private Duty Nursing Manual

MANUAL CONTENTS

Information for All Providers


 [Policy Guidelines](#)

 [Fee Schedule](#)

 [Procedure Codes](#)

 [Provider Training Videos](#)

 [PDN Slide Deck from September 15, 2020 Webinar](#)

 **Billing Guidelines**

 [Private Duty Nursing Billing Guidelines](#)


 [General Professional Billing Guidelines](#)


 [General Remittance Guidelines](#)

 [Prior Approval Guidelines](#)

 [Prior Approval Business Location Chart](#)

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 [Private Duty Nursing Manual Archive](#)

 [Private Duty Nursing Provider Communications](#)

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Private Duty Nursing Resources

PDN Billing Guidelines




Private Duty Nursing Manual

MANUAL CONTENTS

Information for All Providers

 [Policy Guidelines](#)


 [Fee Schedule](#)


 [Procedure Codes](#)

 [Provider Training Videos](#)

 [PDN Slide Deck from September 15, 2020 Webinar](#)

Billing Guidelines

 [Private Duty Nursing Billing Guidelines](#)


 [General Professional Billing Guidelines](#)


 [General Remittance Guidelines](#)

 [Prior Approval Guidelines](#)

 [Prior Approval Business Location Chart](#)

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 [Private Duty Nursing Manual Archive](#)

 [Private Duty Nursing Provider Communications](#)

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Private Duty Nursing Resources

PDN Prior Approval Guidelines



Private Duty Nursing Manual

MANUAL CONTENTS

Information for All Providers

 [Policy Guidelines](#)

 [Fee Schedule](#)

 [Procedure Codes](#)

 [Provider Training Videos](#)


 [PDN Slide Deck from September 15, 2020 Webinar](#)

Billing Guidelines

 [Private Duty Nursing Billing Guidelines](#)


 [General Professional Billing Guidelines](#)

 [General Remittance Guidelines](#)

 [Prior Approval Guidelines](#)

 [Prior Approval Business Location Chart](#)

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 [Private Duty Nursing Manual Archive](#)

 [Private Duty Nursing Provider Communications](#)

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Medically Fragile Children and Adult Program




Private Duty Nursing Manual

MANUAL CONTENTS

Information for All Providers

 [Policy Guidelines](#)

 [Fee Schedule](#)

 [Procedure Codes](#)

 [Provider Training Videos](#)

 [PDN Slide Deck from September 15, 2020 Webinar](#)

Billing Guidelines

 [Private Duty Nursing Billing Guidelines](#)

 [General Professional Billing Guidelines](#)

 [General Remittance Guidelines](#)

 [Prior Approval Guidelines](#)

 [Prior Approval Business Location Chart](#)

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[Private Duty Nursing Provider Communications](#)

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Prior Approval - General Information

- **Prior Approval (PA) for all PDN services is required before the start of providing services**
- **A PA request must be submitted by a Medicaid enrolled PDN or PDN Agency and ordered by a Medicaid enrolled Physician or Nurse Practitioner**
- **It is the provider's responsibility to obtain and submit all necessary paperwork**
- **Approval of PDN services will be for a period of up to six months**
- **Full disclosure of primary insurance must be made to Medicaid. Providers must submit for approval to the primary insurance before requesting PDN hours from Medicaid**
- **Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines**


Private Duty Nursing Prior Approval Request

PRIOR APPROVAL FORM (eMedNY 361502)

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM **ORDER/PRIOR APPROVAL REQUEST**

ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		M M D D C C Y Y	CLIENT TELEPHONE NUMBER	SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME			TELEPHONE NUMBER		LOC CODE
ADDRESS							
DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOD	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

DO NOT STAPLE IN BARCODE AREA



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NOTE: Prior Approval can also be requested electronically and on ePACES

ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
MM/DD/YYYY			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	

1	PRESCRIBED BY (NAME)	PRESCRIBER
ADDRESS	PRESCRIBER	CODE
CITY	STATE	ZIP CODE
ORDER DESCRIPTION/MEDICAL JUSTIFICATION		

Provider Type (Field 1)
Place an X in the box labeled Nursing

SERVICING PROVIDER NUMBER	SERVICING PROVIDER NAME	TELEPHONE NUMBER	LDC CODE
	ADDRESS		

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

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ORDER DATE

PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	ADDRESS		
ADDRESS		PRESCRIBER TELEPHONE NUMBER	DATE OF BIRTH	CITY	STATE	ZIP CODE
			SEX	M	F	

Order Date (Field 2)
 Indicate the month, day, and year on which the order was initiated.
 Example: July 11th, 2022 = 07112022

DRUG CODE (NDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

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ORDER DATE	PREScribing PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)	PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME			
ADDRESS	PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE	ZIP CODE	

Prescribing Provider Number (Field 3)
 Enter the 10 digit Prescribing Provider's Number (NPI)

SERVICING PROVIDER NUMBER	SERVICING PROVIDER NAME	TELEPHONE NUMBER	LDC CODE
ADDRESS			

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

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NOTE: Prescribing Provider is also referred to as the Ordering or Referring Provider

ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE

Prescribed By (NAME) (Field 5)
 Enter the last name followed by the first name of the practitioner initiating the order

SERVICING PROVIDER NUMBER	SERVICING PROVIDER NAME	TELEPHONE NUMBER	LDC CODE
ADDRESS			

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTALT	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

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ORDER DATE MM D D C C Y Y	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY STATE ZIP CODE			PRESCRIBER SIGNATURE		M M D D C C Y Y	CLIENT TELEPHONE NUMBER	SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Prescriber's Address (Field 6)
Enter the Prescriber's address

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

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ORDER DATE MM D D C C Y Y	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER			DATE OF BIRTH	CITY STATE ZIP CODE
CITY STATE ZIP CODE	PRESCRIBER SIGNATURE			M M D D C C Y Y		CLIENT TELEPHONE NUMBER	SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Prescriber Telephone Number (Field 7)
Enter the Prescriber's telephone number

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

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ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
MM/DD/YYYY			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
PRESCRIBED BY (NAME)					ADDRESS		
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE			CLIENT TELEPHONE NUMBER	
					MM/DD/YYYY	SEX	M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Prescriber Signature (Field 8)
 The ordering practitioner must sign the form in this field. **If the form is filled out by the nurse provider who has the written order on something other than the eMedNY 361502, the provider must maintain the signed order in his/her files for six (6) years following the date of payment. A copy of the written order must be submitted with the form.**


5							
6							
7							

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ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>	
N M D D C C Y Y					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
PRESCRIBED BY (NAME)								ADDRESS		
ADDRESS					PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE	ZIP CODE
1	CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE			M M D D C C Y Y	CLIENT TELEPHONE NUMBER		SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION										
<p>Primary Diagnosis (Field 9) Enter the ICD-10 diagnosis code that represents the condition or symptom of the client that establishes the need for the service requested.</p>										
1										
2										
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6										
7										
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ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>		
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID			CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	ADDRESS			
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		CLIENT TELEPHONE NUMBER		CITY	STATE	ZIP CODE
ORDER DESCRIPTION/MEDICAL JUSTIFICATION									

Client ID (Field 11)

Enter the client's eight-character alphanumeric Welfare Management System (WMS) ID number

NOTE: WMS ID numbers are composed of eight characters. The first two are alpha, the next five are numeric and the last is an alpha.

Example: AA12345A

7

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PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		MM/DD/CCYY	CLIENT TELEPHONE NUMBER	
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Client Name (Field 12)
 Enter the last name followed by the first name of the client as it appears on the member's Medicaid ID Card.

1							
2							
3							
4							
5							
6							
7							

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ORDER DATE MMDDCCYY	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	ADDRESS	
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		MMDDCCYY	CLIENT TELEPHONE NUMBER	SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Client Address (Field 13)
Enter the client's address

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

DO NOT STAPLE IN BARCODE AREA



PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER


ORDER DATE MMDDCCYY	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>	
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME		
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH MMDDCCYY	CITY	STATE ZIP CODE	
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE			CLIENT TELEPHONE NUMBER		SEX M M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION								

Client Date of Birth (Field 14)
Indicate the month, day, and year of the client's birth.

Example: April 5th, 1960 = 04051960

2																		
3																		
4																		
5																		
6																		
7																		

DO NOT STAPLE IN BARCODE AREA



PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

ORDER DATE MM D D C C Y Y	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		M M D D C C Y Y	CLIENT TELEPHONE NUMBER	
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Client Telephone Number (Field 15)
Enter the client's telephone number

DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

DO NOT STAPLE IN BARCODE AREA



PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

ORDER DATE MMDDCCYY	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)			PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME	
ADDRESS			PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		M M D D C C Y Y	CLIENT TELEPHONE NUMBER	SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							

Client Sex (Field 16)
Place an X on M for Male or F for Female to indicate the client's gender

DRUG CODE (NDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION	QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED
1			Y N				
2			Y N				
3			Y N				
4			Y N				
5			Y N				
6			Y N				
7			Y N				

DO NOT STAPLE IN BARCODE AREA



PA REVIEW OFFICE CODE

↑
← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER


ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)		PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME		
ADDRESS		PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE	ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE		CLIENT TELEPHONE NUMBER	SEX	M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							
SERVICING PROVIDER NUMBER	SERVICING PROVIDER NAME		TELEPHONE NUMBER		LDC CODE	ADDRESS	
DO NOT STAPLE IN BARCODE AREA							
PA REVIEW OFFICE CODE			↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER				

Order Description / Medical Justification (Field 17)
 The order description must include the objectives of treatment, the estimated duration of treatment, the length of time per day, and the number of days per week that nursing services are necessary. In addition, the specific procedures that the nurse will undertake to justify the need for either a registered professional or licensed practical nurse should be entered.

ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>	
N M D D C C Y Y					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME			
PRESCRIBED BY (NAME)											ADDRESS			
ADDRESS					PREScriBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE	
CITY		STATE		ZIP CODE		PREScriBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER		SEX M F		
ORDER DESCRIPTION/MEDICAL JUSTIFICATION														
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE				
		ADDRESS												
DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTAL	DESCRIPTION				QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED				
1			Y N											
5			Y N											
6			Y N											
7			Y N											
DO NOT STAPLE IN BARCODE AREA														
PA REVIEW OFFICE CODE										↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER				

Servicing Provider Number (Field 18)
 Enter the Servicing Nurse's 10 digit NPI number.




ORDER DATE			PRESCRIBING PROVIDER NUMBER			PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>		
N M D D C C Y Y							PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME				
PRESCRIBED BY (NAME)												ADDRESS					
ADDRESS						PREScriBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE			
CITY			STATE			ZIP CODE			PREScriBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER		SEX	M	F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION																	
SERVICING PROVIDER NUMBER			SERVICING PROVIDER NAME						TELEPHONE NUMBER			LDC CODE					
ADDRESS																	
DRUG CODE (NDC)		PROCEDURE/ITEM CODE		MOQ	RENTALT	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED		TOTAL AMOUNT REQUESTED			
1																	
2																	
PA REVIEW OFFICE CODE																	
 <p>← ↑ ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER</p>																	

Servicing Provider Name (Field 19)
 Enter the name of the independently enrolled private practicing nurse or the name of the LHHCSA agency that will provide care. If more than one provider within the same category of service will be sharing the prior approval, list all providers and their 10 digit NPI numbers in Field 17.

ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>		
N M D D C C Y Y					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME				
PRESCRIBED BY (NAME)											ADDRESS				
ADDRESS					PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE		
CITY		STATE		ZIP CODE		PRESCRIBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER		SEX M F			
ORDER DESCRIPTION/MEDICAL JUSTIFICATION															
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE					
ADDRESS															
DRUG CODE (NDC)		PROCEDURE/ITEM CODE		MOQ	RENTAL	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED		TOTAL AMOUNT REQUESTED	
1					Y N										
2					Y N										
5					Y N										
6					Y N										
7					Y N										
DO NOT STAPLE IN BARCODE AREA															
PA REVIEW OFFICE CODE										↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER					

Servicing Provider Address (Field 20)
 Enter the address of the provider listed in Field 19



ORDER DATE		PRESCRIBING PROVIDER NUMBER			PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>			
N M D D C C Y Y						PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME					
PRESCRIBED BY (NAME)												ADDRESS					
ADDRESS						PRESCRIBER TELEPHONE NUMBER				DATE OF BIRTH		CITY		STATE	ZIP CODE		
CITY		STATE	ZIP CODE	PRESCRIBER SIGNATURE				M M D D C C Y Y		CLIENT TELEPHONE NUMBER		SEX	M	F			
ORDER DESCRIPTION/MEDICAL JUSTIFICATION																	
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE							
		ADDRESS															
DRUG CODE (NDC)		PROCEDURE/ITEM CODE		MOQ	RENTAL	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED	TOTAL AMOUNT REQUESTED				
1					Y N												
2					Y N												
5					Y N												
6					Y N												
7					Y N												
DO NOT STAPLE IN BARCODE AREA																	
						PA REVIEW OFFICE CODE				↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER							

Servicing Provider Telephone Number (Field 21)
 Enter the telephone number of the provider listed in Field 19.

ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>	
N M D D C C Y Y					PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME		
PRESCRIBED BY (NAME)							ADDRESS			
ADDRESS					PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE	ZIP CODE
CITY	STATE	ZIP CODE		PRESCRIBER SIGNATURE			M M D D C C Y Y	CLIENT TELEPHONE NUMBER		SEX M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION										
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				
		ADDRESS								
DRUG CODE (INDC)	PROCEDURE/ITEM CODE	MOQ	RENTALT	DESCRIPTION			QUANTITY REQUESTED	TIMES REQUESTED	TOTAL AMOUNT REQUESTED	
1										
2										
PA REVIEW OFFICE CODE							↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER			

LOC CODE

Servicing Provider Location Code (Field 22)
 Enter the three-digit location code to specify where you would like to receive PA related correspondence.
 Example: 003



ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>		
N M D O C C Y Y					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME				
PRESCRIBED BY (NAME)											ADDRESS				
ADDRESS					PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE		
CITY STATE ZIP CODE					PRESCRIBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER				SEX M F		
ORDER DESCRIPTION/MEDICAL JUSTIFICATION															
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE					
		ADDRESS													
DRUG CODE (INDC)		PROCEDURE / ITEM CODE		MOO	RENTAL	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED		TOTAL AMOUNT REQUESTED	
1					Y N										
2					Y N										
3					Y N										
DO NOT STAPLE IN BARCODE AREA															
PA REVIEW OFFICE CODE										↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER					

PROCEDURE / ITEM CODE

Procedure / Item Code (Field 24)
 This code indicates the service to be rendered to the Client. Enter the appropriate five-character code. RN = S9123 LPN = S9124



ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>		
N M D D C C Y Y					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME				
PRESCRIBED BY (NAME)											ADDRESS				
ADDRESS					PREScriBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE		
CITY STATE ZIP CODE					PREScriBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER				SEX M F		
ORDER DESCRIPTION/MEDICAL JUSTIFICATION															
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE					
		ADDRESS													
DRUG CODE (NDC)		PROCEDURE/ITEM CODE		MOD	RENTAL	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED		TOTAL AMOUNT REQUESTED	
1					Y N										
2					Y N										
3					Y N										
4					Y N										
5					Y N										
6					Y N										
7					Y N										
DO NOT STAPLE IN BARCODE AREA															
PA REVIEW OFFICE CODE										↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER					

Modifier (Field 25)

Enter the appropriate two-character modifier, if required.



ORDER DATE			PRESCRIBING PROVIDER NUMBER			PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>			DME / SUPPLIES <input checked="" type="checkbox"/>			NURSING <input checked="" type="checkbox"/>			EYE CARE <input checked="" type="checkbox"/>			PHYSICIAN <input checked="" type="checkbox"/>				
N M D D C C Y Y																							
PRESCRIBED BY (NAME)						PRIMARY DIAGNOSIS			SECONDARY DIAGNOSIS			CLIENT ID			CLIENT NAME								
ADDRESS						PRESCRIBER TELEPHONE NUMBER			DATE OF BIRTH			CITY			STATE			ZIP CODE					
CITY						STATE			ZIP CODE			PRESCRIBER SIGNATURE			M M D D C C Y Y			CLIENT TELEPHONE NUMBER			SEX	M	F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION																							
SERVICING PROVIDER NUMBER			SERVICING PROVIDER NAME						TELEPHONE NUMBER						LDC CODE								
			ADDRESS																				
DRUG CODE (INDC)			PROCEDURE/ITEM CODE			MOO	RENTAL	DESCRIPTION			QUANTITY REQUESTED			TIMES REQUESTED			TOTAL AMOUNT REQUESTED						
1																							
2																							
3																							


Description (Field 27)
 Enter the description of the service corresponding to the procedure code entered in Field 24.

DO NOT STAPLE IN BARCODE AREA



PA REVIEW OFFICE CODE

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 ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER

ORDER DATE MM/DD/YYYY			PRESCRIBING PROVIDER NUMBER			PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>			
PRESCRIBED BY (NAME)						PRIMARY DIAGNOSIS			SECONDARY DIAGNOSIS			CLIENT ID		CLIENT NAME				
ADDRESS						PRESCRIBER TELEPHONE NUMBER			DATE OF BIRTH		CITY		STATE		ZIP CODE			
CITY			STATE			ZIP CODE			PRESCRIBER SIGNATURE			M M D D C C Y Y		CLIENT TELEPHONE NUMBER		SEX	M	F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION																		
SERVICING PROVIDER NUMBER			SERVICING PROVIDER NAME						TELEPHONE NUMBER				LDC CODE					
ADDRESS																		
DRUG CODE (NDC)			PROCEDURE/ITEM CODE		MOO	RENTAL	DESCRIPTION					QUANTITY REQUESTED		DAYS REQUESTED	TOTAL AMOUNT REQUESTED			
1						Y	N											
2						Y	N											
7						Y	N											
DO NOT STAPLE IN BARCODE AREA																		
																		
PA REVIEW OFFICE CODE												↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER						

Quantity Requested (Field 28)


Enter the total number of hours of private duty nursing services for all the days for which prior approval is being requested

ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>	
N M D D C C Y Y					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME			
PRESCRIBED BY (NAME)											ADDRESS			
ADDRESS					PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE	
CITY STATE ZIP CODE					PRESCRIBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER				SEX M F	
ORDER DESCRIPTION/MEDICAL JUSTIFICATION														
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE				
		ADDRESS												
DRUG CODE (INDC)		PROCEDURE/ITEM CODE		MOO	RENTALT	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED	TOTAL AMOUNT REQUESTED	
1					Y N									
2					Y N									
3					Y N									
7					Y N									
DO NOT STAPLE IN BARCODE AREA														
PA REVIEW OFFICE CODE										↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER				



Times Requested (Field 29)
 Enter the number of days on which private duty nursing services are requested.



ORDER DATE		PRESCRIBING PROVIDER NUMBER		PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>		DME / SUPPLIES <input checked="" type="checkbox"/>		NURSING <input checked="" type="checkbox"/>		EYE CARE <input checked="" type="checkbox"/>		PHYSICIAN <input checked="" type="checkbox"/>	
N M D D C C Y Y														
PRESCRIBED BY (NAME)					PRIMARY DIAGNOSIS		SECONDARY DIAGNOSIS		CLIENT ID		CLIENT NAME			
ADDRESS					PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH		CITY		STATE		ZIP CODE	
CITY STATE ZIP CODE					PRESCRIBER SIGNATURE		M M D D C C Y Y		CLIENT TELEPHONE NUMBER		SEX		M	F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION														
SERVICING PROVIDER NUMBER		SERVICING PROVIDER NAME				TELEPHONE NUMBER				LDC CODE				
		ADDRESS												
DRUG CODE (INDC)		PROCEDURE/ITEM CODE		MOO	RENTAL	DESCRIPTION				QUANTITY REQUESTED		TIMES REQUESTED		TOTAL AMOUNT REQUESTED
1					Y N									
2					Y N									
3					Y N									
<p>Total Amount Requested (Field 30) Enter the dollar amount requested for the specific prior-approved service. Calculate this amount, based on the established fee for this client, to cover the total units requested.</p>														
														
PA REVIEW OFFICE CODE										↑ ← ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBER				

ORDER DATE	PRESCRIBING PROVIDER NUMBER	PROF CODE	RX DRUGS / OTC <input checked="" type="checkbox"/>	DME / SUPPLIES <input checked="" type="checkbox"/>	NURSING <input checked="" type="checkbox"/>	EYE CARE <input checked="" type="checkbox"/>	PHYSICIAN <input checked="" type="checkbox"/>
PRESCRIBED BY (NAME)		PRIMARY DIAGNOSIS	SECONDARY DIAGNOSIS	CLIENT ID	CLIENT NAME		
ADDRESS		PRESCRIBER TELEPHONE NUMBER		DATE OF BIRTH	CITY	STATE	ZIP CODE
CITY	STATE	ZIP CODE	PRESCRIBER SIGNATURE	CLIENT TELEPHONE NUMBER		SEX	M F
ORDER DESCRIPTION/MEDICAL JUSTIFICATION							
SERVICING PROVIDER NUMBER	SERVICING PROVIDER NAME		TELEPHONE NUMBER		LOC		

PA Review Office Code (Field 31)
 This field is used to identify the state agency responsible for reviewing and issuing the prior approval

Code
 A1 - Bureau of Medical Review and Payment, Office of Health Insurance Programs, NYS Department of Health

7

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Prior Approval Form - Mailing Addresses

Paper prior approval request forms with appropriate attachments should be sent to:

Regular Mail/Shipping:

eMedNY
PO Box 4600
Rensselaer, NY 12144-4600

Expedited/Priority Shipping:

eMedNY
327 Columbia Turnpike
ATTN: Box 4600
Rensselaer, NY 12144

Important Reminders

- **Prior Approval (PA) for all PDN services is required before the start of providing services**
- **A PA request must be submitted by a Medicaid enrolled PDN or PDN Agency and ordered by a Medicaid enrolled Physician or Nurse Practitioner**
- **It is the provider's responsibility to obtain and submit all necessary paperwork**
- **Approval of PDN services will be for a period of up to six months**

Important Reminders

- **Full disclosure of primary insurance must be made to Medicaid. Providers must submit for approval to the primary insurance before requesting PDN hours from Medicaid**
- **Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines**
- **Prior Approval for PDN services can be requested on paper, electronically and on ePACES**
- **Contact the eMedNY call center at 800-343-9000 to order paper Prior Approval request forms**

Reference and Contact Information

- eMedNY Website
 - www.emedny.org
- Private Duty Nursing Manual
 - www.emedny.org/ProviderManuals/NursingServices/index.aspx
- eMedNY Call Center
 - 800-343-9000

THANK YOU



Department
of Health

Medicaid
Program