AmeriHealth Caritas Delaware

Pediatric Shift Care (PDN/SDAC request form)

Please type this document to ensure accuracy and to expedite processing. All fields must be completed for the request to be processed. Please make a selection where applicable throughout the document.

Date	
Type of request _____ Urgent _____ Standard _____ Retrospective	
Treatment Setting _____ Outpatient	
Request type	_____ Extension _____ Initial _____ Cancel _____ Changes DOS/setting
_____ Additional Clinical _____ Discharge Planning _____ Other	
Previous authorization Number (if applicable)	
Contact name	
Contact phone	Contact fax

Member Information

Last Name		
First Name		
Member ID (Medicaid ID or Health Plan ID)		
Member phone number	Date of Birth	
Member street address		
City	State	ZIP

Provider Information			
Provider Name			
Provider Tin	Provider Npi		
Provider Phone Number	Provider Fax Number		
Provider Street Address			
City		State	Zip
Provider Status _____ Par _____ Non Par _____ In Credentialing			
Facility Name			
Facility Tin	Facility Npi		
Facility Phone Number	Facility Fax Number		
Facility Street Address			
City		State	Zip
Provider Status _____ Par _____ Non Par _____ In Credentialing			
Referring Physician Name (If Different From Above)			
Referring Physician Tin			
Referring Physician Npi			
Referring Physician Phone Number			
Referring Physician Fax Number			
Referring Physician Street Address			
City		State	Zip
Provider Status _____ Par _____ Non Par _____ In Credentialing			

Medical Section

Diagnosis Code		

Procedure Code	Description	Start date – End date	# Hours per week/per day
___ S9123 ___ S9124	Skilled nursing		
___ G0156	Home health aide		
___ S5130 U2	Self-directed attendant care		
___ T2040	Financial management		

Providers are responsible for obtaining prior authorization before services are rendered. Service rendered without prior authorization may result in a denial. Please submit clinical information to support medical necessity for the request. Request will not be processed if clinical information or CPT and ICD-10 codes are missing. Authorization is not a guarantee of payment. If you have an urgent request, please call 1-855-396-5770 to initiate the review process.

Other clinical information
Include or attach any clinical and office notes, doctor's orders, labs, or imaging reports to support medical necessity. If this is an out-of-network request, please provide an explanation and complete the nonparticipating provider form.

Important payment notice
Please note that reimbursement to any rendering provider for an approved authorization is determined by satisfying the mandatory requirement to have a valid Delaware Medical Assistance (MA) provider ID. However, effective January 1, 2018, any claim submitted by a rendering provider will be denied if it is submitted without the ordering/prescribing/referring provider's Delaware MA enrolled NPI, or if the NPI does not match that of a Delaware MA enrolled provider.

To check the Delaware MA enrollment status of the practitioner that is ordering, referring, or prescribing the service you are providing, visit the Delaware Department of Health and Social Services (DHS) provider look-up portal at: **https://medicaid.dhss.delaware.gov/provider**.

AmeriHealth Caritas Delaware