

Pediatric Complex Care Assistant (PCCA) Services Prior Authorization Request



DEPARTMENT OF
**PUBLIC HEALTH &
HUMAN SERVICES**

All PCCA services must be prior authorized. Requests must be renewed every 90 days during the first six months of service, and every six months thereafter or, anytime the condition of the child changes, resulting in a change to the identified service, frequency or time of the PCCA services.

Requests for prior authorization must be submitted to Mountain Pacific through the [Mountain Pacific Provider Portal](#).

Member Information			
Last Name	First Name	Middle Initial	Medicaid ID Number
At Home Status			
Is the member receiving Private Duty Nursing (PDN) at home? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="radio"/> If Yes, number of received hours/day?			
<input type="radio"/> Agency providing PDN is: _____			
Is the member receiving Community First Choice Services/Personal Care Services? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the member receiving Home Health? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="radio"/> If Yes, number of received hours per day or week?			
<input type="radio"/> Expected length of Home Health services?			
<input type="radio"/> Home Health agency is: _____			
In School Status			
Is the member in school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the member receiving Private Duty Nursing (PDN) at school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Provider Information			
Provider Agency Name		Provider Agency NPI	
Agency Contact First and Last Name		Telephone	Fax

Physician Information and Orders		
Ordering Physician Name	Telephone Number	Fax Number
Principal Diagnosis		
Additional Comments		
Request for PCCA Services		
Select the box for each service being requested. Indicate the frequency per day or per week for each service selected. PCCA services are provided where the child resides.		
<input type="checkbox"/> Tracheostomy care	Frequency (per day or per week)	
<input type="checkbox"/> Airway clearance, airway management including oxygen	Frequency (per day or per week)	
<input type="checkbox"/> Enteral care and therapy	Frequency (per day or per week)	
<input type="checkbox"/> Wound care	Frequency (per day or per week)	
<input type="checkbox"/> Central line care or IV fluid administration	Frequency (per day or per week)	
<input type="checkbox"/> Bowel care, including enema administration and ostomy care	Frequency (per day or per week)	
<input type="checkbox"/> Medication administration	Frequency (per day or per week)	
Upload current list of medications when uploading this form.		
Physician Printed Name and Signature		
Physician Printed Name		
Physician Signature		Date