NV LOC PED - FA-22

(REQUIRED ONLY IF SERVICE LEVEL IS PEDIATRIC LEVEL OF CARE)

Please upload this form along with the above LOC through the Provider Web Portal. If you are not an enrolled Nevada Medicaid provider, you may fax this form to **1 (855) 709-6847.** For assistance please contact the Nevada Medicaid Help Desk **1 (800) 525-2395.**

Requesting Facility or Provider Information

Last Name	First Name	Telephone	Fax	Email

Organization ID	Organization Name

Organization Address 1	Organization Address 2

Organization City	Organization State	Organization Zip

Recipient Information

Recipient

Last Name	First Name	Middle Name

Personal Details

Social Security Number	Date of Birth	Recipient's Home or Cell Number	Medicaid ID Number	Medicaid Status	Medicaid County of Residence

Nursing Service Information

The recipient's condition requires 24-hour access to care from a registered nurse **and** there is documentation to support that the recipient has at least one of the following:

◯ Yes ◯ No

☐ A tracheostomy requiring mechanical ventilation a minimum of 6 hours per day or the recipient is on a ventilator weaning program (time limited)

☐ Dependence on Total Parenteral Nutrition (TPN) or other intravenous (IV) nutritional support and at least one treatment procedure listed in the next section

☐ A tracheostomy requiring suctioning, mist or oxygen and at least one treatment procedure listed in the next section

☐ Administration of at least two treatment procedures listed in the next section

TREATMENT PROCEDURES ***(check all that apply)***

☐ Central or peripherally inserted central catheter (PICC) line management

☐ Complex wound care (including stage III or IV decubitous wound or recent surgical or other recent wound) requiring extensive dressing or packing (time limited)

☐ Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy)

☐ Intermittent suctioning at least every eight hours and mist or oxygen as needed

Is there an IV therapy:

◯ Yes ◯ No

Select one that applies:

◯ Administration of continuous therapeutic agents ◯ Hydration ◯ Intermittent IV drug administration of more than one agent

☐ Maximum assist required (quadriplegia or hoyer lift)

☐ Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours

☐ Seizure Precautions

☐ Tube utilization (nasogastric or gastrostomy); foley, intermittent catherization, PEG, rectal tube

☐ Moderate behavior issues (including self abuse)

Describe the problem behavior, frequency and severity:

☐ Other special treatment(s) not listed above - Describe in detail:

DISCHARGE POTENTIAL

Describe the recipient's potential for discharge from the pediatric unit to a lower level of care or home:

JUSTIFICATION

Enter additional comments to support medical necessity of Pediatric Specialty Care Services (attach supporting documentation):

Screener Certification (REQUIRED FOR BOTH FA-19 AND FA-22)

Signature and title of person completing this form: