Letter of Medical Necessity for Shift Care Services

Date: _____

To: Health Partners Plans/Jefferson Health Plans

Re: Request for Shift Care Services

Prescribing Physician Information

Prescribing Physician's Name	
Specialty	
NPI Number	
Practice Name	
Practice Address	
Phone	
Fax	

Patient Information

Patient Name	
Date of Birth (MM/DD/YYYY)	
Insurance ID #	
Case ID# (if applicable)	

Medical Justification

I am writing to request approval for shift care services for my patient, _____ *(Patient Name)* who has been diagnosed with_____ *(Diagnosis with ICD-10 Code)*. The patient's condition necessitates continuous skilled care due to *[provide brief description of medical condition and severity below]*:

The patient requires assistance with the following:

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1101 Market Street, Suite 3000
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- [List ADLs and level of assistance needed: bathing, dressing, feeding, toileting, etc.]

- [Medical needs: medication administration, respiratory support, seizure monitoring, etc.]

- [Therapies: physical, occupational, speech, etc.]

Due to the complexity and intensity of care, it is medically necessary to provide _____ level care for ___ hour(s) per day, ___ days per week, beginning on _____ for an estimated duration of _____.
(RN/LPN/HHA) *(Date)* *(Duration)*

Supporting Clinical Information

- Diagnosis (ICD-10 code): _____
- Severity (describe condition severity and risks without care):
- Treatment Plan (medications, therapies, equipment):
- Past Interventions (prior treatments and outcomes):
- Caregiver Availability (is family trained and available?):
- School/Work Impact (include verification if applicable):

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Requested Services

Day	Start Time	End Time	Total Hours
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Skill Level Requested:

- ☐ RN
- ☐ LPN
- ☐ HHA
- ☐ Medical Day Care

Agency Name (if known): _____

Agency Phone Number: _____

Conclusion

The requested shift care is essential to ensure the patient's safety, prevent deterioration, and support recovery, and quality of life. I respectfully request that this care be authorized as medically necessary.

Sincerely,

Physician's Signature:

_____

Physician's Name:

_____

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