Provider Statement of Need

The Provider Statement of Need (PSON) is required prior to the authorization of Personal Assistance Services (PAS), Personal Care Services (PCS) or Habilitation (HAB). These are ***non-technical attendant services*** authorized for eligible individuals who have a medical condition resulting in a functional limitation in performing personal care. Attendants help individuals with activities of daily living, such as bathing, grooming and meal preparation. Attendants are trained and supervised by non-medical personnel.

The PSON form below must be signed by a Physician, Nurse Practitioner (NP) or Physician Assistant (PA) who has examined the member and reviewed the medical record within the last 12 months.

Instructions: Please completely fill out the form below. Obtain a signature by the Physician, NP or PA in the Provider Signature line and return the form by fax to **1-866-703-0502**, or electronically with an Adobe e-Signature to **SHP.Intake@SuperiorHealthPlan.com**.

For any questions, concerns or to discuss this member's care, please call Superior at **1-844-433-2074** (STAR Kids), **1-866-912-6283** (STAR Health), **1-877-277-9772** (STAR+PLUS) or **1-855-772-7075** (STAR+PLUS MMP).

Member Information: ☐ Initial request for services ☐ Reassessment

Member Name:	
Medicaid Member ID:	
Member Date of Birth:	

Section A. Has this patient been examined within the last 12 months?

YES	NO
☐ Yes, I hereby certify that this individual has been examined within the past 12 months. **If certifying Yes, please complete Section B. and section C.**	☐ No, I am unable to certify that this individual has been examined within the past 12 months. **If certifying No, please bypass Section B. and complete Section C.**

Section B. Does this patient need the non-technical attendant services described above?

YES	NO
☐ Yes, I hereby certify that this individual has a medical need resulting in one or more functional limitations, as indicated below. If the medical need is temporary, I anticipate the need will end on this date: _____ *(If the medical need is not temporary, this line may be left blank.)*	☐ No, I am unable to certify that this individual has a medical need resulting in one or more functional limitations. **If certifying No, please bypass functional limitations and complete Section C.**

If certifying Yes, please check all functional limitations related to the member's medical diagnoses:

☐ Bedfast	☐ Behavioral/emotional problems	☐ Blackouts	☐ Chair bound	☐ Cognitive impairment
☐ Contractures	☐ Difficulty swallowing	☐ Dizziness	☐ Falls Easily	☐ General weakness
☐ Hearing impairment	☐ Incontinence	☐ Limited dexterity	☐ Limited mobility	☐ Limited range of motion
☐ Nausea	☐ Numbness	☐ Pain	☐ Paralysis	☐ Shortness of breath
☐ Spasticity	☐ Tremors	☐ Unable to stand for long	☐ Vision impairment	☐ Other: _____

Section C.

		☐ MD ☐ DO ☐ NP ☐PA	
Provider Printed Name	Provider Signature	Credentials	Date
Provider Phone Number	Provider Fax Number		