Department of HUMAN SERVICES

{Current Date}

Re: {Member Name}, {State ID Last 4}
PA#: {MED PA Number}

Dear {Provider Name}:

The prior authorization request and supporting documentation for , dates of service , has been reviewed. It has been determined that can be approved. In order to allow the family and member time to adjust to the decreased hours, a plan is needed to allow a gradual decrease in the amount of time the nurse/home health aide is providing service until the supported level of service is met. This can be done over a week time period. Please submit a plan using the space provided on this form of how you would like to decrease the hours from to . Your plan will be reviewed after received and approved if deemed reasonable. Also, indicate if you or the child's parents/guardians would like a care conference to discuss the plan. If you disagree with the reduction, please provide rationale below.

Plan for decreasing hours from to :

_____
_____
_____
_____
_____
_____

Would you like a care conference scheduled to discuss this plan? ☐ Yes ☐ No
If yes, please list names and phone numbers of people to be involved in the conference call and dates and times when they will be available:

_____
_____
_____

Please complete and return Iowa Department of Human Services, PO Box 36478, Des Moines, IA 50315, or fax to 515-725-1356 within 10 calendar days. Thank you for your prompt response.

Sincerely,

Iowa Medicaid Enterprise
Quality Improvement Organization Services - Prior Authorization

470-4821 (01/19)