

## Episodic Authorization Request Form

**Please Note:** Authorization request must be submitted in the first 14 days of the episode.

Attn: myNEXUS Episodic Provider Team

## EPISODIC AUTHORIZATION REQUEST FORM

### For Reauthorization and Add On-Skills for an Existing Authorization

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: **844-438-6791**

**Please note:** If the member was hospitalized while receiving care under an authorization or has signed a NOMNC, a new authorization is required. For a new authorization, please use the "Initial Authorization Request" form.

Questions? Call **833-845-8684**

**FOR FASTER AUTHORIZATION PLEASE VISIT:**

<https://portal.mynexuscare.com>

<b>Date of Request:</b>	<b>Standard Request:</b> <input type="checkbox"/>  <b>Retro Request:</b> <input type="checkbox"/>	<b>Urgent Request:</b> <input type="checkbox"/> <b>Note: Urgent request should only be submitted if</b> waiting for a decision under the standard time frame could place the enrollee's <b>life, health, or ability to regain maximum function</b> in serious jeopardy. If member's condition does not meet this description and the authorization is submitted as an Urgent Request, delays in processing may occur.		
<b>Member Name:</b>  <b>DOB:</b>  <b>Member ID# (required):</b>	<b>Agency:</b> _____ <b>NPI (required):</b> _____ <b>Requestor Name:</b> _____ <b>Phone:</b> _____ <b>Request Requires Review per the Portal? Y/N. If Y, Reason;</b>			
<b>AUTHORIZATION NUMBER:</b>  <b>Start of Care Date:</b>	<b>Able/willing/teachable caregiver?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no, please explain:</b>			
<b>Following/Plan of Care Physician/NP (required):</b> _____ <b>Phone:</b> _____ <b>Fax:</b> _____ <b>NPI:</b> _____				
<b>Diagnosis:</b>	<b>Code</b>	<b>Description</b>		
Primary				
Secondary				
Tertiary				
Quaternary				
<b>HIPPS (required)</b>				
<b>Residence:</b> <input type="checkbox"/> Independent Living <input type="checkbox"/> Long Term care <input type="checkbox"/> Other: <input type="checkbox"/> Assisted Living <input type="checkbox"/> Private				
<b>Agency Recommendations/Request:</b>				
<b>Discipline</b>	<b># Visits</b>	<b>From</b>	<b>To</b>	<b>Frequency</b>
<b>REQUIRED CHECKLIST:</b> The 2 requirements listed below are required for the review process. Please submit this completed form along with the listed requirements. <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>MD Home Healthcare signed order (Including signed verbal MD order)</b></li> <li><input type="checkbox"/> <b>Supporting Clinical Documentation: OASIS, Plan of Care, Visit Notes, any Evaluations completed and wound measurements from previous SN visits.</b></li> </ul>				
<b>Comments/ Notes:</b>				