myNEXUS — Humana

HOME HEALTH CARE AUTHORIZATION REQUEST FORM

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

Questions? Call 833-845-8684

FOR FASTER AUTHORIZATION PLEASE VISIT: https://portal.mynexuscare.com

Date of Request:	**Standard Request:** ☐ **Retro Request:** ☐	**Urgent Request:** ☐ **Note: Urgent request should only be submitted if** waiting for a decision under the standard time frame could place the enrollee's **life, health, or ability to regain maximum function** 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.

Member Name: **DOB:**	**Referral Source:** ***Required for Authorization Notification*** **Phone:** **Fax:**
Member ID# (Required):	**Referral Source:** ☐ **Hospital** ☐ **SNF/Rehab** ☐ **MD Office** ☐ **HH Agency**
Date of D/C from facility or office visit: **Has home health care already begun?** ☐ **Yes** ☐ **No** **Start of Care Date/ Requested start of care date:**	**Preferred HH Provider:** **Branch NPI (required):** **Phone:**
Diagnosis: (incl. Codes) **HIPPS Code:**	**Ordering MD (required):**____________________ **Ordering MD NPI (required):** ____________________ **Phone:** **Fax:**
HOMEBOUND STATUS: Yes ☐ **No:** ☐ **CMS Definition:** Homebound status certified by MD; there is a normal inability to leave home and leaving the home is a considerable and taxing effort.	**Able/willing/teachable caregiver?** ☐ **Yes** ☐ **No** **If no, please explain:**

What is Being Requested:	Reason for visits:
Skilled Nursing (include wound measurements, name/dosage frequency of medications if applicable)	☐ Wound Care ☐ Foley or PEG care ☐ Access Care (port/PICC) ☐ Teaching/Compliance ☐ Other:
PT (all therapy requests should include current level of function and care goals)	☐ Evaluate and Treat
ST	☐ Communication ☐ Other ☐ Cognitive ☐ Swallowing
MSW **HHA** **OT**	To avoid potential non-authorization, please include the **completed initial assessment** and **qualifying service Care Plan** with all Dependent Service visits requests.

REQUIRED INFORMATION:

- ☐ **MD Home Healthcare signed order (Including signed verbal MD order)**
- ☐ **Supporting Clinical Documentation**

At least one of the following is required:

- ☐ History and Physical
- ☐ Facility Discharge Summary
- ☐ Progress Notes from Hospital or SNF
- ☐ MD Office Notes
- ☐ Wound Care Pictures and Measurements

Comments/ Notes:

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