

HOME HEALTH CARE Re-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>

Date of Request:	Standard Request: <input type="checkbox"/> Retro Request: <input type="checkbox"/>	Urgent Request: <input type="checkbox"/> 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: Member ID# (Required):	Agency: _____ NPI (required): _____ Requestor Name: _____ Phone: _____ Request Requires Review per the Portal? Y/N. If Y, Reason;			
AUTHORIZATION NUMBER: Start of Care Date:	Able/willing/teachable caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:			
Following/Plan of Care Physician/NP (required): _____ Phone: _____ Fax: _____ NPI: _____				
Diagnosis:	Code	Description		
Primary				
Secondary				
Tertiary				
Quaternary				
HIPPS				
Residence: <input type="checkbox"/> Independent Living <input type="checkbox"/> Long Term care <input type="checkbox"/> Other: <input type="checkbox"/> Assisted Living <input type="checkbox"/> Private				
Agency Recommendations/Request:				
Discipline	# Visits	From	To	Frequency
REQUIRED CHECKLIST: The 2 requirements listed below are required for the review process. Please submit this completed form along with the listed requirements.				
<input type="checkbox"/> MD Home Healthcare signed order (Including signed verbal MD order)				
<input type="checkbox"/> Supporting Clinical Documentation: OASIS, Plan of Care, Visit Notes, any Evaluations completed and wound measurements from previous SN visits.				
Comments/ Notes:				