



# HOME HEALTH CARE AUTHORIZATION REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 866-996-0077

Questions? Call 833-585-6262

**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: Expedited organization determinations (urgent requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS regulation: 40.8)
Member Name: DOB: Member State of Residence:	Referral Source: _____ NPI: _____ <i>Required for Authorization Notification</i> Phone: _____ Fax: _____	
Health/Benefit Plan ID: Member ID# (Required):	Referral Source: <input type="checkbox"/> Hospital <input type="checkbox"/> SNF/Rehab <input type="checkbox"/> MD Office <input type="checkbox"/> HH Agency	
Date of D/C from facility or office visit:	Preferred HH Provider: _____ Phone: _____	
Has home health care already begun? <input type="checkbox"/> Yes <input type="checkbox"/> No Start of Care Date:	Requestor Email (Required): _____ Branch NPI (Required): _____ Fax (Required): _____	
Diagnosis (include codes):  HIPPS Code:	Ordering MD (Required): _____ Ordering MD NPI (Required): _____ Phone: _____ Fax: _____	
HOMEBOUND STATUS: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:	

**Clinical Grouping:** myNEXUS uses clinical groupings for initial authorization. Select ONE of the clinical groupings from the left column below and all disciplines with a MD order. If none selected, myNEXUS will use the general clinical grouping.

<b>REQUIRED INFORMATION:</b> <b>Clinical Grouping: <u>CHOOSE ONE:</u></b> <input type="checkbox"/> General Home Care <input type="checkbox"/> Total Hip Replacement <input type="checkbox"/> Total Knee Replacement <input type="checkbox"/> Wound <input type="checkbox"/> Wound Vac <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Foley <input type="checkbox"/> B-12 Injection <input type="checkbox"/> Sepsis <input type="checkbox"/> IV Injection	<b>Which Disciplines are Ordered for the Start of Care?</b> <input type="checkbox"/> Skilled Nursing	<b>REQUIRED INFORMATION:</b> <input type="checkbox"/> MD Home Healthcare signed order or signed verbal order <input type="checkbox"/> Supporting Clinical Documentation  <b>At least <u>ONE</u> of the following is required:</b> <input type="checkbox"/> H&P <input type="checkbox"/> Inpatient Discharge Summary <input type="checkbox"/> Notes from Hospital or SNF <input type="checkbox"/> MD Office Notes <input type="checkbox"/> Wound Care Notes and Measurements
	<input type="checkbox"/> Physical Therapy	
	<input type="checkbox"/> Occupational Therapy	
	<input type="checkbox"/> Speech Therapy	
	<input type="checkbox"/> Home Health Aide	
	<input type="checkbox"/> Medical Social Worker	

Comments:

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