



**HOME HEALTH CARE Re-AUTHORIZATION REQUEST FORM**  
**For Reauthorization and Add On-Skills for an Existing Authorization**

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

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

**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 833-585-6262**

<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"/> <small>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)</small>			
<b>Member Name:</b> _____ <b>DOB:</b> _____ <b>Member ID# (required):</b> _____ <b>Member State of Residence:</b> _____ <b>Health/Benefit Plan ID:</b> _____		<b>Agency (required):</b> _____ <b>NPI (required):</b> _____ <b>Requestor Name (required):</b> _____ <b>Requestor Email (required):</b> _____ <b>Phone(required):</b> _____ <b>Fax(required):</b> _____			
<b>AUTHORIZATION NUMBER:</b> _____  <b>Start of Care Date: (required):</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>NPI (required):</b> _____ <b>Fax:</b> _____					
<b>Diagnosis:</b>	<b>Code</b>	<b>Description</b>	<b>HIPPS CODE:</b>	<b>Residence:</b>	
Primary			<input type="checkbox"/> _____	<input type="checkbox"/> Private Residence	
Secondary				<input type="checkbox"/> Assisted Living	
Tertiary				<input type="checkbox"/> Independent Living	
Quaternary				<input type="checkbox"/> Long Term Care	
				<input type="checkbox"/> Other: _____	
<b>Agency Request: (Filling out the dates and grid below are required)</b> <b>Certification Period dates? From: _____ To: _____ (must match Plan of Care date range)</b>					
<b>Discipline</b>	<b>If discipline was previously approved, what date was the last visit used?</b>	<b># Visits being requested</b>	<b>From</b>	<b>To</b> <small>(may not request past cert period end date)</small>	<b>Frequency on Plan of Care</b>
<input type="checkbox"/> SN					
<input type="checkbox"/> PT					
<input type="checkbox"/> OT					
<input type="checkbox"/> ST					
<input type="checkbox"/> HHA					
<input type="checkbox"/> MSW					
<b>REQUIRED CHECKLIST:</b> The 3 requirements listed below are required for the review process. Please submit this completed form along with the listed requirements. <ol style="list-style-type: none"> <li>1. Verbal or Signed order if a new skill is being requested.</li> <li>2. For the first Re-Authorization request please submit the completed OASIS.</li> <li>3. Updated clinical documentation for all services being requested. Along with all visit notes, please ensure the evaluation is being or has been submitted.</li> </ol> <b>** Wound Care- provide wound measurements from previous visits</b>					
<b>Comments/ Notes:</b> _____					