# 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:*** *844-834-2908*

***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*** *844-411-9622*

| Date of Request: | Standard Request: ☐<br>Retro Request: ☐ | Urgent Request: ☐<br>Note: Expedited organization determinations (urgent requests), can only be requested by the Member (or their representative) or a Physician. See CMS regulation: 50.1 |
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|---|---|
| Member Name:________________________<br>DOB: ________________<br>Member ID# (Required): ________________<br>Member State of Residence: _____________<br>Health/Benefit Plan ID: | Agency(required): __________________________________________<br>NPI (required): ____________________<br>Requestor Name(required): _________________________________<br>Requestor Email(required): __________________________________<br>Phone(required): ________________________ Fax(required): ____________________ |
| AUTHORIZATION NUMBER:<br><br>Start of Care Date: (required): | Able/willing/teachable caregiver? ☐ Yes ☐ No<br>If no, please explain: |

Following/Plan of Care Physician/NP (required): _______________________________ Phone:
NPI (required): Fax:

| Diagnosis: | Code | Description | HIPPS CODE: | Residence: |
|---|---|---|---|---|
| Primary | | | ☐_____________ | ☐Private Residence |
| Secondary | | | | ☐Assisted Living |
| Tertiary | | | | ☐Independent Living |
| Quaternary | | | | ☐Long Term Care |
| | | | | ☐Other: ________________ |

**Agency Request:** (Filling out the dates and grid below are required)

**Certification Period dates? From: ___________ To: ___________ (must match Plan of Care date range)**

| Discipline | If discipline was previously approved, what date was the last visit used? | # Visits being requested | From | To (may not request past cert period end date) | Frequency on Plan of Care |
|---|---|---|---|---|---|
| ☐ SN | | | | | |
| ☐ PT | | | | | |
| ☐ OT | | | | | |
| ☐ ST | | | | | |
| ☐ HHA | | | | | |
| ☐ MSW | | | | | |

**REQUIRED CHECKLIST:** The 3 requirements listed below are required for the review process. Please submit this completed form along with the listed requirements.

1. Verbal or Signed order if a new skill is being requested.
2. For the first Re-Authorization request please submit the completed OASIS.
3. Updated clinical documentation for all services being requested. Along with all visit notes, please ensure the evaluation is being or has been submitted.

** Wound Care- provide wound measurements from previous visits

Comments/ Notes:

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