myNEXUS

Episodic Authorization Request Form

Please Note: Authorization request must be submitted in the first 14 days of the episode.

Attn: myNEXUS Episodic Provider Team

EPISODIC 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:** ☐ **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:** **Member ID# (required):**		**Agency:** _____ **NPI (required):** _____ **Requester Name:** _____ **Phone:** **Request Requires Review per the Portal? Yes☐ No☐ If Yes, please list reason below:**
AUTHORIZATION NUMBER: **Start of Care Date:**		**Able/willing/teachable caregiver? ☐ Yes ☐ No** **If no, please explain:**

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

Diagnosis:	**Code**	**Description**
Primary		
Secondary		
Tertiary		
Quaternary		
HIPPS (required)		

Residence: ☐ Independent Living ☐ Assisted Living ☐ Long Term care ☐ Private ☐ Other:

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.

- ☐ **MD Home Healthcare signed order (Including signed verbal MD order)**
- ☐ **Supporting Clinical Documentation: OASIS, Plan of Care, Visit Notes, any Evaluations completed and wound measurements from previous SN visits.**

Comments/ Notes:

CONFIDENTIALITY NOTICE: This fax message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or may otherwise be protected by law. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by fax and destroy all copies of the original message and any attachment thereto.