



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: 844-438-6791

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

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 (or their representative) or a Physician. See CMS regulation: 50.1			
Member Name: _____ DOB: _____ Member ID# (Required): _____ Member State of Residence: _____ Health/Benefit Plan ID: _____		Agency(required): _____ NPI (required): _____ Requestor Name(required): _____ Requestor Email(required): _____ Phone(required): _____ Fax(required): _____			
AUTHORIZATION NUMBER: _____ Start of Care Date: (required): _____		Able/willing/teachable caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____			
Following/Plan of Care Physician/NP (required): _____ Phone: _____ NPI (required): _____ Fax: _____					
Diagnosis:	Code	Description	HIPPS CODE:	Residence:	
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: _____	
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
<input type="checkbox"/> SN					
<input type="checkbox"/> PT					
<input type="checkbox"/> OT					
<input type="checkbox"/> ST					
<input type="checkbox"/> HHA					
<input type="checkbox"/> MSW					
REQUIRED CHECKLIST: 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"> 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. <p>** Wound Care- provide wound measurements from previous visits</p>					
Comments/ Notes: _____					