myNEXUS

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HUMANA | myNEXUS®

HOME HEALTH PROVIDER FAX CONFIRMATION FORM

PLEASE FAX THIS COMPLETED FORM TO: 629-204-3053

myNEXUS is committed to protecting member's Protected Health Information (PHI). To prevent disclosure of PHI to unauthorized recipients, myNEXUS requires confirmation of your phone and fax number. **myNEXUS must receive this completed form prior to faxing authorization notifications.**

If you have questions regarding this form, please contact our Provider Data Management team at ProviderDataManagement@myNEXUScare.com or call (615) 610-5815.

Thank you for your assistance in protecting member's PHI.

Date of Confirmation: _____	**Name of person completing confirmation form:** _____ **Contact Phone # (in case clarification is needed):** _____

If you are confirming multiple locations, you may attach a list of the locations, along with the information requested below.

Provider Branch Name (official W-9 Name):	
DBA Name (if app):	
NPI:	**TIN:**
Branch Address:	**City, State:**
Branch Phone #:	***Please note, all faxes for authorization and/or requests for additional documents will be sent to this fax number.***
Branch Fax #:	

If your company has a central authorization department that will be processing authorization requests for multiple branches, please also complete the information below.

Parent Company Name:	I want all communication for members for the above branch listed to go through the central auth department phone/fax: ☐ Yes ☐ No
Authorization Dept Contact Phone #:	
Authorization Dept Fax #:	