myNEXUS

HOME HEALTH CARE AUTHORIZATION REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 866-936-1635

Questions? Call 833-866-0393

FOR FASTER AUTHORIZATION, PLEASE VISIT:
https://portal.myNEXUScare.com

Date of Request:	**Standard Request:** ☐ **Retro Request:** ☐	**Urgent Request:** ☐ **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 State of Residence:**		**Referral Source:** **NPI:** ***Required for Authorization Notification*** **Phone:** **Fax:**
Health/Benefit Plan ID: **Member ID# (Required):**		**Referral Source:** ☐**Hospital** ☐**SNF/Rehab** ☐**MD Office** ☐**HH Agency**
Date of D/C from facility or office visit:		**Preferred HH Provider:** **Phone:**
Has home health care already begun? ☐ **Yes** ☐ **No** **Start of Care Date:**		**Requestor Email (Required):** **Branch NPI (Required):** **Fax (Required):**
Diagnosis (include codes): **HIPPS Code:**		**Ordering MD (Required):** _____ **Ordering MD NPI (Required):** _____ **Phone:** **Fax:**
HOMEBOUND STATUS: ☐ **Yes** ☐ **No** **CMS Definition:** Homebound status certified by MD; there is a normal inability to leave home and leaving the home is a considerable and taxing effort.		**Able/willing/teachable caregiver?** ☐ **Yes** ☐ **No** **If no, please explain:**

Clinical Grouping: myNEXUS uses clinical groupings for initial authorization. Select ONE of the clinical groupings from the left column below and all disciplines with a MD order. If none selected, myNEXUS will use the general clinical grouping.

REQUIRED INFORMATION:

Clinical Grouping: *CHOOSE ONE:*

- ☐ General Home Care
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Wound
- ☐ Wound Vac
- ☐ CHF
- ☐ COPD
- ☐ Diabetes
- ☐ Stroke
- ☐ Behavioral Health
- ☐ Heart Surgery
- ☐ Chemotherapy
- ☐ Foley
- ☐ B-12 Injection
- ☐ Sepsis
- ☐ IV Injection

Which Disciplines are Ordered for the Start of Care?

- ☐ Skilled Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Home Health Aide
- ☐ Medical Social Worker

REQUIRED INFORMATION:

☐ MD Home Healthcare signed order or signed verbal order

☐ Supporting Clinical Documentation

At least <u>ONE</u> of the following is required:

- ☐ H&P
- ☐ Inpatient Discharge Summary
- ☐ Notes from Hospital or SNF
- ☐ MD Office Notes
- ☐ Wound Care Notes and Measurements

Comments: