



# HOME HEALTH CARE AUTHORIZATION REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 844-438-6791

Questions? Call 833-845-8684

**FOR FASTER AUTHORIZATION, PLEASE VISIT:**

<https://portal.mynexuscare.com>

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 State of Residence:	Referral Source: <i>Required for Authorization Notification</i> Phone: NPI: Fax:	
Health/Benefit Plan ID: Member ID# (Required):	Referral Source: <input type="checkbox"/> Hospital <input type="checkbox"/> SNF/Rehab <input type="checkbox"/> MD Office <input type="checkbox"/> HH Agency	
Date of D/C from facility or office visit:	Preferred HH Provider: Requestor Email (Required): Branch NPI (Required):	Phone: Fax (Required):
Has home health care already begun? <input type="checkbox"/> Yes <input type="checkbox"/> No Start of Care Date:	Ordering MD (Required): _____ Ordering MD NPI (Required): _____ Phone: Fax:	
Diagnosis (include codes): HIPPS Code:	Ordering MD (Required): _____ Ordering MD NPI (Required): _____ Phone: Fax:	
HOMEBOUND STATUS: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<b>REQUIRED INFORMATION:</b> <b>Clinical Grouping: CHOOSE ONE:</b> <input type="checkbox"/> General Home Care <input type="checkbox"/> Total Hip Replacement <input type="checkbox"/> Total Knee Replacement <input type="checkbox"/> Wound <input type="checkbox"/> Wound Vac <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Foley <input type="checkbox"/> B-12 Injection <input type="checkbox"/> Sepsis <input type="checkbox"/> IV Injection	<b>Which Disciplines are Ordered for the Start of Care?</b> <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Medical Social Worker	<b>REQUIRED INFORMATION:</b> <input type="checkbox"/> MD Home Healthcare signed order or signed verbal order <input type="checkbox"/> Supporting Clinical Documentation <p><b>At least ONE of the following is required:</b></p> <input type="checkbox"/> H&P <input type="checkbox"/> Inpatient Discharge Summary <input type="checkbox"/> Notes from Hospital or SNF <input type="checkbox"/> MD Office Notes <input type="checkbox"/> Wound Care Notes and Measurements

Comments:

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