

Home Health Agency – Intermittent Services

DATE OF REQUEST: ____/____/____

REQUEST TYPE: Initial Continued Services
 Retrospective* Unscheduled Revision

* For a Retrospective request, enter the date the recipient was determined Medicaid eligible:

____/____/____

For questions regarding this form, call: (800) 525-2395

Form Submission options:

- Upload form using the Provider Web Portal at www.medicaid.nv.gov

• Fax to: (866) 480-9903

• Mail to: Nevada Medicaid

Attention: Prior Authorization

6511 SE Forbes Ave., Bldg 283

P.O. Box 19287

Topeka, KS 66619-0287

For questions regarding this form, call: (800) 525-2395.

To request Durable Medical Equipment (DME) supplies, please attach form FA-1.

NOTES:

REQUESTED SERVICE DATES

Anticipated Start Date:

Anticipated End Date:

RECIPIENT INFORMATION

Recipient Name:

Recipient ID:

Date of Birth:

Indicate which program(s) the recipient is eligible for: Healthy Kids (EPSDT) Katie Beckett Waiver Program N/A

Medicare Insurance Eligibility: Part A Part B N/A

Medicare ID#:

Other Insurance Name:

Other Insurance ID#:

Describe the recipient's social situation (check all that apply):

Recipient lives with family

Teachable

Capable of doing self-care

Recipient lives alone

Not teachable

Unable to do self-care

Foster Home

Support Available

Group Home

Support Unavailable

RESPONSIBLE PARTY LEGALLY RESPONSIBLE INDIVIDUAL (LRI) INFORMATION (if other than the recipient)

Name:

Phone:

Address (include city, state, zip code):

Relationship to recipient:

GUARDIAN INFORMATION (if other than the recipient)

Name:

Phone:

Address (include city, state, zip code):

Relationship to recipient:

ORDERING PROVIDER INFORMATION (Physician ordering home health agency services)

Name:

NPI:

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Phone:	Fax:
SERVICING PROVIDER INFORMATION <i>(Home health agency to provide home health agency services)</i>	
Name:	NPI:
Phone:	Fax:
Contact Name:	Miles from Home Health Agency to recipient's home:
Where does this provider render services? <input type="checkbox"/> In Nevada (includes catchment areas) <input type="checkbox"/> Outside Nevada	
CLINICAL INFORMATION	
Date of Registered Nurse Evaluation:	Date of Last Physician Visit:
Primary Diagnosis <i>(include ICD-10 code(s))</i> :	
Additional Diagnosis(es) <i>(include ICD-10 code(s))</i> :	
Summary of Recipient Needs	
Description of Recipient's Functional Deficit(s) <i>(to be addressed by Home Health Agency services)</i>	
Interventions to be Provided and Measurable Short-Term and Long-Term Treatment Goals	

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Skilled Needs (please check all that apply)

- Catheter Care Central Line ~~G-tube~~ Enteral Feeding IV Antibiotics Medication Setup
- New Ostomy Care PICC Line Teaching Trach Care Vent Care
- Wound Care Other (specify): _____

Wound Care (complete this page-section only if requesting wound care services)

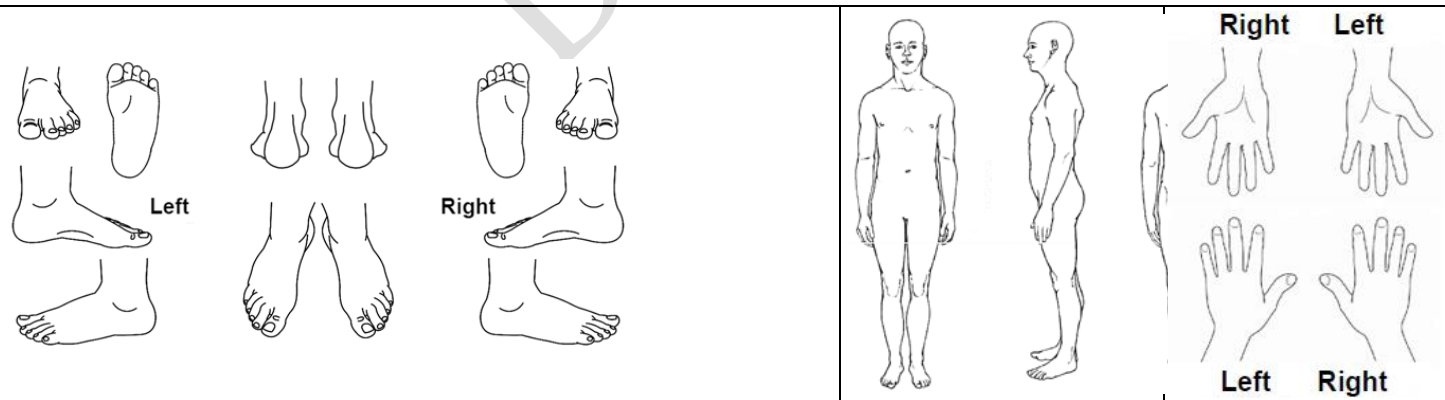
Goal of Care: To Heal To Maintain To Monitor/Manage

History of the wound (e.g., onset, longevity, current management):

Wound Type/Etiology (if known):

- Pressure Venous Arterial Diabetic Surgical 2° Intention Skin Tear Other: _____

Mark location of wound/ulcer with an arrow or an "X"



Wound Measurements (in cm): Length: _____ cm Width: _____ cm Depth: _____ cm Thickness: Partial full

If Pressure Ulcer, indicate stage: Stage 1 Stage 2 Stage 3 Stage 4 Unstageable

Tissue Appearance:

Sinus tracts/tunneling:

- Wound Edges: Attached (flush w/wound bed or "sloping edge") Non-Attached (edge appears as a "cliff")
 Rolled (curled under) Epithelialization Other: _____

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Surrounding Skin: Intact Erythema (reddened) in cm: _____ Indurated (firmness around wound) in cm: _____
 Macerated (white, waterlogged) Excoriated/Denuded (superficial loss of tissue) Callused
 Fragile Other: _____

Exudate Amount (check one): None Scant/Small Moderate Large/Copious

Exudate Type (check all that apply): Serous Sanguineous Purulent Other: _____

Wound Treatment Plan as Prescribed by Physician (include intervention, frequency, duration, etc.)

Note: Disposable wound supplies will be authorized for the Home Health Agency for an initial 10-day supply only; thereafter, the supplies must be obtained from a Durable Medical Equipment or Pharmacy provider.

REQUESTED SERVICES (To request Durable Medical Equipment (DME) supplies, please attach form FA-1.)

I anticipate home health agency services will be required: From: ____/____/____ To: ____/____/____

of Recognized[†] Holidays Requested (include procedure code with TV modifier and appropriate units in table below): _____

- Column 1:** Enter the procedure code (HCPCS). Enter only one code per line. Include modifier if needed.
- Column 2:** Enter the appropriate abbreviation to describe the servicing provider:
RN (Registered Nurse), LPN (Licensed Practical Nurse), HHA (Home Health Aide), PT (Physical Therapist), OT (Occupational Therapist), SLP (Speech Language Pathologist), RT (Respiratory Therapist), D (Dietitian).
- Column 3:** Specify the length of visit (in minutes).
- Column 4:** Specify the units per visit.
- Column 5:** Enter the number of requested visits per week.
- Column 6:** Enter the number weeks for which service is requested.
- Column 7:** Enter the total number of units requested for each procedure code.

1	2	3	4	5	6	7
Procedure Code (including modifier(s))	Provider/Therapy	Length of Visit	Units per Visit	Visits per Week	Duration (Weeks)	Total Units Requested
1.						
2.						
3.						
4.						
5.						

[†] Nevada Medicaid recognizes the following holidays: New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Nevada Admission Day (last Friday in October), Veteran's Day, Thanksgiving Day, Family Day (the day after Thanksgiving), and Christmas Day. Recognized holidays are the same days that State offices are closed. A holiday rate may only be requested/billed for holidays recognized by the Home Health Agency and for which Home Health Agency staff are paid a corresponding holiday rate.

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6.						
7.						
8.						
9.						
10.						

REQUESTING PROVIDER (ORDERING PHYSICIAN)

Name:

NPI:

Signature:

Date:

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.

DRAFT

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HOME HEALTH FACE-TO-FACE DOCUMENTATION

Complete this page **only** for initial orders for home health services
and for all episodes initiated with the completion of a start-of-care OASIS assessment.

RECIPIENT INFORMATION

Recipient Name:

Recipient ID:

FACE-TO FACE-ENCOUNTER (Note: The physician or non-physician practitioner who performed the face-to-face encounter must communicate the clinical findings to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the recipient's medical record.)

Performed by: _____ MD/DO PA APRN

Location: Inpatient Facility Outpatient Office Recipient's Home Other: _____

Date: _____ Telehealth used? Yes No

PATIENT DIAGNOSIS/REASON FOR HOME HEALTH

VISIT FINDINGS TO SUPPORT NEED FOR HOME HEALTH SERVICES

DISCIPLINES ORDERED (please check all that apply).

Skilled Nursing PT OT SLP Home Health Aide Respiratory Therapy Dietitian

ORDERING PHYSICIAN'S CERTIFICATION STATEMENT

I certify by signing below that this patient is under my care and that a face-to-face encounter with the above-named individual was conducted within ninety days prior to the home health services start of care date, or within thirty days following the start of care date, preceding this certification.

Physician Printed Name:

Date:

Physician Signature: