Prior Authorization Request
Nevada Medicaid and Nevada Check Up

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:

_____/_____/_____

Form Submission:

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

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	

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 *(Practitioner ordering home health agency services)*	
Name:	NPI:
Phone:	Fax:

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SERVICING PROVIDER INFORMATION *(Home health agency to provide home health agency services)*	
Name:	NPI:
Phone:	Fax:
Contact Name:	Miles from Home Health Agency to recipient's home:
Where does this provider render services? ☐ In Nevada (includes catchment areas) ☐ Outside Nevada	

CLINICAL INFORMATION	
Date of Registered Nurse Evaluation:	Date of Last Physician Visit:
Primary Diagnosis *(include ICD-10 code)*:	
Additional Diagnosis(es) *(include ICD-10 code(s)):*	

Summary of Recipient Needs

Description of Recipient's Functional Deficit(s) *(to be addressed by Home Health Agency services)*

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 ☐ Enteral Feeding ☐ IV Antibiotics ☐ Medication Setup
☐ New Ostomy Care ☐ PICC Line ☐ Teaching ☐ Trach Care ☐ Vent Care
☐ Wound Care ☐ Other *(specify)*: _____
_____

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

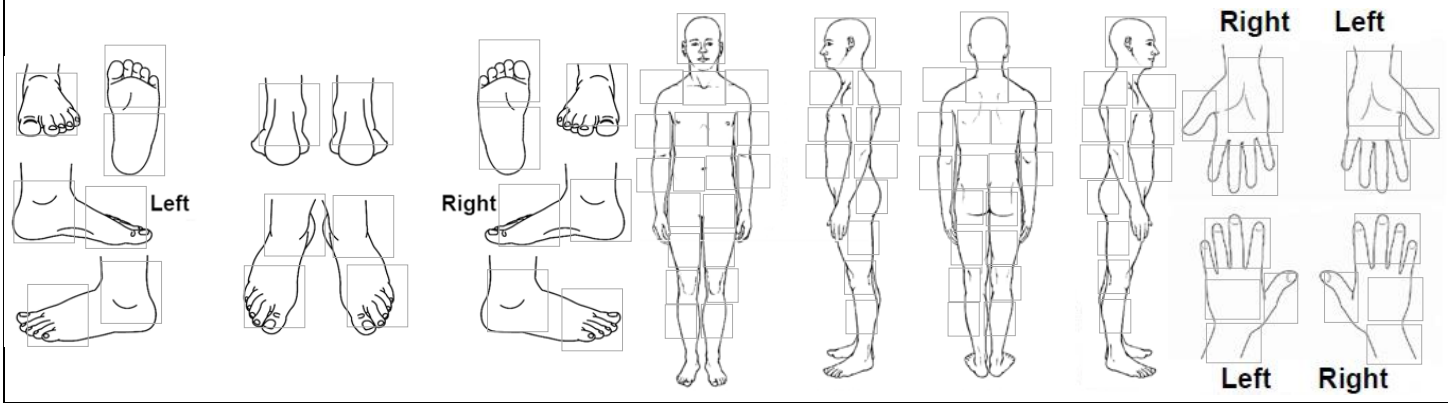
Goal of Care: ☐ To Heal ☐ To Maintain ☐ To Monitor/Manage

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: _____

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: _____

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Wound Treatment Plan as Prescribed by Ordering Practitioner *(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

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.						
6.						
7.						
8.						
9.						
10.						

REQUESTING PROVIDER (ORDERING PRACTITIONER)

Name:	NPI:
Signature:	Date:

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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 PRACTITIONER'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/Physician's Assistant/APRN Printed Name:	**Date:**

Physician/Physician's Assistant/APRN Signature: