

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:

Recipient Name: _____ Date of Request: _____

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? <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)</i> :	
Additional Diagnosis(es) <i>(include ICD-10 code(s))</i> :	

Summary of Recipient Needs

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

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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)

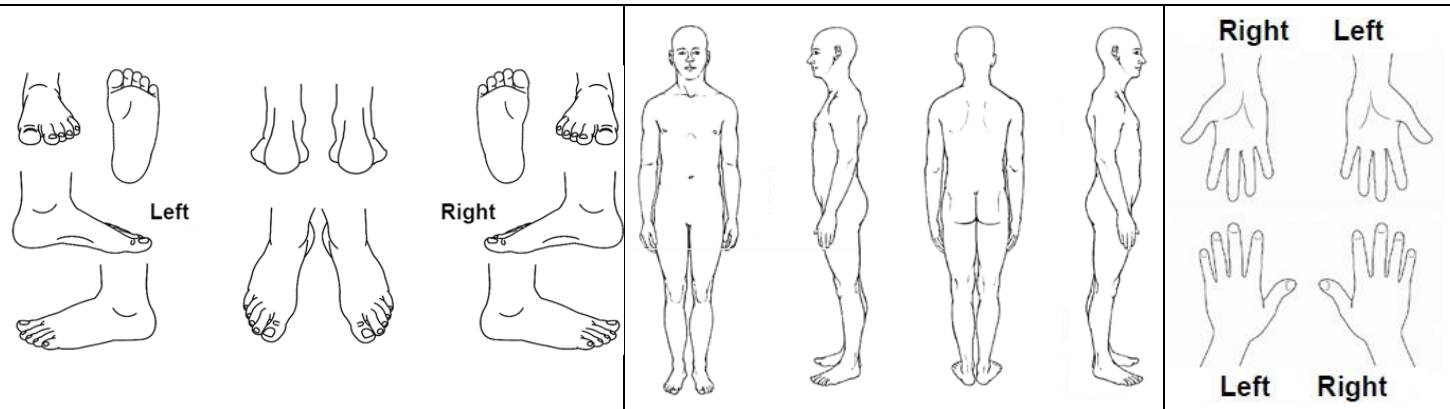
Goal of Care: ☐ To Heal ☐ To Maintain ☐ To Monitor/Manage

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:

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.

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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: _____ Date of Request _____

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: _____