Prior Authorization Request
Hewlett Packard Enterprise - Nevada Medicaid and Nevada Check Up

Adult Day Health Care (ADHC)

Purpose: To request prior authorization for ADHC services through the Nevada Medicaid program.

Required Attachments: The Service Plan must be submitted with this request. When faxing, please submit this page as the first page of the request packet. If the recipient is currently receiving ADHC services with another provider, form FA-29A (Request for Termination of Service) must be submitted along with form FA-17.

Notes: Services are dependent on medical necessity and may be approved for a maximum of 1 year. If Hewlett Packard Enterprise needs additional information to make a determination for your request, you will be notified by mail and in the Provider Web Portal. You will have five business days to submit the requested information or the request will be denied for insufficient information (a "technical denial"). When complete information is submitted, Hewlett Packard Enterprise will make a determination within five business days and the authorization information will then be visible in the Provider Web Portal. Please do not re-fax unless you are directed to do so.

Please review the Billing Guidelines for Provider Type 39 available on the Providers Billing Information webpage.

Fax this form and the required attachments to: (855) 709-6846 **Questions? Call:** (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

REQUEST TYPE: ☐ Initial/New ☐ Continuing ☐ Revised

SECTION I: RECIPIENT INFORMATION	
Recipient Name:	Date of Birth:
Recipient Medicaid ID:	Phone:
Mailing Address:	
Current Residence: ☐ Independent Living ☐ Group Care/Assisted Living ☐ Other:	
SECTION II: ADHC FACILITY INFORMATION	
Name:	NPI:
Phone:	Fax:
Physical Address:	
Name and professional title of person completing sections I, II and III of this form: Name: Title:	
Contact Phone:	Contact Fax:
SECTION III: REQUESTED SERVICES	
Requested begin date of service:	Requested end date of service: *(Must be last day of the month)*
Requested number of days per week:	ICD-10 Code:
Choose one: ☐ **S5102** *(Attends 6 or more hours per day)* ☐ **S5100** *(Attends less than 6 hours per day or schedule varies between less than or more than 6 hours per day)*	
SECTION IV: UNIVERSAL NEEDS ASSESSMENT / PHYSICIAN, APRN OR PA EVALUATION	
Date of Examination:	Assessor Name:
Address of Assessor:	
Contact Phone:	Fax Number: NPI:
Assessor is a *(check one)*: ☐ Physician ☐ Advanced Practice Registered Nurse ☐ Physician's Assistant Assessor's State Board Medical or Nursing or Medical Examiner License Number:	

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Recipient's Vital Signs: Blood Pressure:____/____ Pulse:_____ Respirations:_____ Temperature:_____

Tuberculosis Screening:

Option 1 2-Step TB Skin Test: ☐ Yes ☐ No

Date 1st Test: _____ Results: _____
Date 2nd Test: _____ Results: _____

Enter the Lot # and Expiration Date if the TB testing was done in the physician's office:

Lot #: _____ Expiration Date: _____
Lot #: _____ Expiration Date: _____

Option 2 Quantiferon Gold: ☐ Yes or ☐ No Date: _____ Results:_____

Option 3 If the recipient has had a positive TB skin test, complete the following:

Chest X-Ray (only if patient has documented history of Positive skin test): Date: _____

Results: _____

Signs and Symptoms Checklist: (to be completed annually for a recipient after a positive TB skin test has been documented.)

Date of screening:_____

☐ Yes ☐ No Cough lasting three or more weeks
☐ Yes ☐ No Anorexia (loss of appetite)
☐ Yes ☐ No Night sweats
☐ Yes ☐ No Coughing up blood
☐ Yes ☐ No Unexplained weight loss
☐ Yes ☐ No Fever
☐ Yes ☐ No Fatigue
☐ Yes ☐ No BCG Vaccine

Fall Risk:

Has the client fallen in the past six months? ☐ Yes ☐ No

Specify: _____

Does this patient have any infectious diseases? ☐ Yes ☐ No

Specify: _____

Nutritional Needs/Special Diet: ☐ Yes ☐ No

Specify: _____

Physician Orders (examples include Durable Medical Equipment, Physical Therapy, Occupational Therapy, Speech Therapy, Special Diet, etc.):

Medical History:

Diagnosis:_____

History/Physical: _____

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Clinical Information *(Check all applicable boxes to indicate substantial impairments, risk factors and needs)*

Treatment /Special Needs (check all that pertain and explain below):

☐ Trach ☐ Suctioning ☐ O2 ☐ Colostomy ☐ External Catheter ☐ PICC ☐ Saline-Lock
☐ Feeding Tube (G-tube, J-tube, NG tube) ☐ Wound Care ☐ Glucose Monitoring ☐ Insulin Dependent
☐ Medication Management ☐ Nebulizer Treatment ☐ Foley Catheter ☐ Vital Signs/Blood Pressure Monitoring ☐ Other: _____

For all items checked above, indicate who performs it, frequency, duration, location of wound and specific treatments:

Substance Abuse: ☐ Yes ☐ No *(This individual has been diagnosed with a substance abuse problem that will be addressed at the ADHC facility and that primarily contributes to his/her need for ADHC services)*

Multiple Social Service System Involvement: ☐ Yes ☐ No *(This individual is involved in multiple social service systems (e.g., criminal justice system or welfare systems) OR multiple case managers from various public and/or community organization and multi-system agencies related to the recipient's unmet needs.)*

Activities of Daily Living: *(Check all activities with which recipient needs assistance and add applicable comments)*

☐ Dressing ☐ Eating ☐ Hygiene ☐ Bathing ☐ Mobility ☐ Transfer ☐ Bladder ☐ Bowel ☐ Grooming

Comments:

Need for Supervision: *(Check all boxes that pertain)*

☐ Wandering ☐ Resists Care ☐ Socially Inappropriate ☐ Verbally Abusive ☐ Behavior Problem
☐ Safety Risk ☐ Physically Abusive ☐ Visually Impaired ☐ Hearing Impaired

Cognitive/Behavior: *(Check all boxes that pertain)*

☐ Speech/ Language/Communication ☐ Self-Direction ☐ Social Development ☐ Learning
☐ Vocational Development ☐ Maladaptive Behavior ☐ Psychosis/Hallucinations ☐ Mild Memory Loss
☐ Moderate Memory Loss

PHYSICIAN, APRN OR PA VERIFICATION AND SIGNATURE

This person is appropriate for Adult Day Health Care Services (ADHC) ☐ Yes ☐ No

I have completed an examination of the above named individual, and based on the finding documented in this section, I consider this individual appropriate for Adult Day Health Care (ADHC) services.

Physician/APRN/PA Signature: **Date:**

SECTION V: RECIPIENT VERIFICATION AND SIGNATURE

I am choosing to attend an Adult Day Health Care facility. If there is more than one facility in my area, I verify that I have been offered a choice of facilities.

Recipient 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.