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| **MARYLAND DEPARTMENT OF HEALTH**  **REMOTE PATIENT MONITORING**  **PREAUTHORIZATION FORM** | **Home Health Providers:**  FAX: 410-333-5085  ATTN: Tia Lyles | **Other Health Professionals:**  FAX: 410-333-5050  ATTN: Monasha Holloway |

**SECTION I: PATIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| FULL NAME | DOB | MEDICAID NUMBER |
| HOME ADDRESS | | |

**SECTION II: PAY-TO PROVIDER INFORMATION**

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| --- | --- | --- | --- |
| FULL NAME | NPI | | MEDICAID PROVIDER NUMBER |
| PHONE | | FAX | |

**SECTION III: RENDERING PROVIDER INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| FULL NAME | NPI | | MEDICAID PROVIDER NUMBER |
| PHONE | | FAX | |

**SECTION IV: QUALIFYING CONDITIONS**

**For qualifying condition, mark 1 and circle corresponding ICD10(s).** Both qualifying events should have same primary qualifying condition but may have different ICD10s. Example: *COPD, ICD10: J44.1 and J44.9.*

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| Diabetes Mellitus  ICD-10: |
| Chronic Obstructive Pulmonary Disease (COPD )  ICD-10: |
| Congestive Heart Failure (CHF)  ICD-10: |

**SECTION V: QUALIFYING EVENTS**

**Please mark 1.**

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| Recipient had **2 hospital admissions** within the prior 12 months with the same qualifying medical condition as the **primary diagnosis**. |
| Recipient had **2 emergency department visits** within the prior 12 months with the same qualifying medical condition as the **primary diagnosis**. |
| Recipient had **1 hospital admission and 1 emergency department visit** within the prior 12 months with the same qualifying medical condition as the **primary diagnosis**. |

**SECTION VI: ATTESTATIONS AND SIGNATURE (Please initial all that apply.)**

\_\_\_\_ Patient is not getting similar service from another provider.

\_\_\_\_ Patient is felt to be at high risk for repeat hospital utilization and this monitoring will reduce the risk.

\_\_\_\_ Patient has the ability to utilize the monitoring equipment and has stated a willingness to do so at the requested frequency every day.

\_\_\_\_ Patient is not residing in a hospital, nursing facility, or other medical or psychiatric institution.

\_\_\_\_ The ordering provider, if not the rendering provider, has (or will) alerted the service provider to the monitoring values which require immediate notification. **(Home Health Agencies only)**

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SIGNATURE (Physician, Physician Assistant, or Nurse Practitioner) DATE

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| --- |
| **Department Use Only**  \_\_\_ Approved \_\_\_ Denied  Processor Name and Date: |