|  |  |  |
| --- | --- | --- |
| **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**

|  |  |  |
| --- | --- | --- |
| 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.*

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

**SECTION V: QUALIFYING EVENTS**

**Please mark 1.**

|  |
| --- |
| [ ]  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)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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