ASTHMA REMEDIATION REFERRAL FORM

Environmental asthma trigger remediations are physical modifications to a home environment that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. The services are available in a home that is owned, rented, leased or occupied by the member or their caregiver. For more information, review the Asthma Remediation Authorization Guide.

Complete and submit this referral form with the *Outpatient Medicaid – Prior Authorization Fax Form* either online (recommended) at **www. CAHealthWellness.com** or by **fax at 866-724-5057**.

Initial request **Extension request**

Member consented to asthma remediation referral

Type of Request (check all that apply)

Allergen-impermeable mattress and pillow dustcovers	Other moisture-controlling interventions
High-efficiency particulate air (HEPA) filtered vacuums	Minor mold removal and remediation services
Integrated Pest Management (IPM) services	Ventilation improvements
De-humidifiers	Asthma-friendly cleaning products and supplies
Air filters	Other interventions identified to be medically appropriate and cost effective

Eligibility Criteria

Individuals with poorly controlled asthma as determined by a licensed health care provider who has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits or other high-cost services, including:

An emergency department visit or hospitalization.

OR

Two sick or urgent care visits in the past 12 months.

OR

A score of 19 or lower on the asthma control test.

Member Information

Member name:		**Date of birth (DOB)**:
Medi-Cal ID:	**Phone number:**	**Preferred language:**
Home address:		
Contact name: **(if different than member)**		**Relationship:**
Phone number:		**Preferred language:**
Member height:		**Member weight:**
Member's diagnosis (*related to asthma remediation need*):		

Member's need for asthma remediation:

Community Supports Provider Information (Servicing Organization)	
Organization name:	
Tax identification (ID):	**National Provider Identifier (NPI):**
Staff name:	**Title:**
Phone number:	**Fax number**:

Required Documents (upload documents with the referral form)

Clinical documentation submitted by the member's current primary care physician or other health professional (medical doctor, physician assistant or nurse practitioner).

Provider order – A current licensed health care provider's order specifying the requested remediation(s) for the member.

Evaluation – A brief written evaluation specific to the member describing how and why the remediation(s) meets the needs of the individual; required for cases of other interventions identified to be medically appropriate and cost-effective.

Additional documentation submitted by Community Supports provider or others.

A home visit – conducted to determine the suitability of any requested remediation(s) for the member. The home visit may occur post-referral by provider.

Date of home visit: _____

or

Date of scheduled home visit:_____