NORTHCOAST HEALTH CARE MANAGEMENT Services, Ltd.

PEER TO PEER REVIEW REQUEST FOR ANTHEM MA HOME HEALTH CARE DENIAL

FAX THIS FORM WITH REQUIRED INFORMATION TO: 216-591-2504

or via secure email to: casemanagement@northcoastgroup.org Questions? Call 800-757-7111, option 5

SUBMIT THIS FORM AND REQUIRED DOCUMENTATION ASAP

HHC Name:	**Submission Date:**	
Contact Name:	**Phone:**	**Fax:**
Member Name:	**DOB:**	
Member ID#:	**Case Reference Number:**	
Post Hospital Discharge: ☐ **Yes** ☐ **No**	**Hospital Discharge Date:**	**Start of Care Date:**
Following/Plan of Care Physician (required):		
Physician NPI:	**Phone:**	**Fax:**
Diagnosis Codes: (Please list up to 4 ICD-10 codes)		
IS PATIENT HOMEBOUND? ☐ **Yes** ☐ **No**	**CMS homebound definition:** *MD certifies patient requires assistance or is medically contraindicated; and requires considerable and taxing effort to leave home. Absences are infrequent/short duration or attributable to the need for health care treatment.*	

Services Denied (please include date range of denied visits)	**Reason for visits** (please attach current clinical related to reason)	**Reason for Peer to Peer Request** Please explain why you disagree with the decision on your request (provide as much detail as needed to justify the medical necessity for the requested services):
Skilled Nursing **#Visits:** _____ **Dates:** From _____ To_____	☐ Wound Care ☐ Foley or PEG care ☐ Access Care (PICC/port) ☐ Teaching/Compliance ☐ Injections ☐ Other: _____	
Physical Therapy **#Visits:** _____ **Dates:** From _____ To_____	☐ Home Assessment ☐ Exercise/Strengthening ☐ AD/Equipment Training ☐ Energy Conservation ☐ Home Exercise Program ☐ Other: _____ ☐ Safety	
Occupational Therapy **#Visits:** _____ **Dates:** From _____ To_____	☐ Strengthening ☐ Safety ☐ Other: _____	
Speech Therapy **#Visits:** _____ **Dates:** From _____ To_____	☐ Communication ☐ Other ☐ Cognitive ☐ Swallowing	
Home Health Aide **#Visits:** _____ **Dates:** From _____ To_____	☐ Assist with ADL's ☐ Functional impairment ☐ Other: _____	
Medical Social Worker **#Visits:** _____ **Dates:** From _____ To_____		

Able/willing/teachable caregiver? ☐ **Yes** ☐ **No** **If no, please explain:**

Additional Comments:

CONFIDENTIALITY NOTICE: The material in this fax, including any attachments, is either private, confidential, privileged, or constitutes work product protected by law, and is intended only for the use of the individual(s) named. If you are not the intended recipient, be advised that unauthorized use, disclosure, copying, distribution, or the taking of any action in reliance of this information is strictly prohibited. If you have received this transmission in error, please contact the sender by fax and permanently destroy it immediately.

This form adapted using the Proprietary myNEXUS, Inc. Initial and Re-Authorization forms found at www.mynexuscare.com