

## 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 *Medi-Cal – Prior Authorization Request Form – Outpatient* either online (recommended) at **provider.healthnetcalifornia.com** or by fax at **800-743-1655**.

<input type="checkbox"/> <b>Initial request</b> <input type="checkbox"/> <b>Extension request</b> <input type="checkbox"/> <b>Member consented to asthma remediation referral</b>		
<b>Type of Request (check all that apply)</b>		
<input type="checkbox"/> Allergen-impermeable mattress and pillow dustcovers <input type="checkbox"/> High-efficiency particulate air (HEPA) filtered vacuums <input type="checkbox"/> Integrated Pest Management (IPM) services <input type="checkbox"/> De-humidifiers <input type="checkbox"/> Air filters	<input type="checkbox"/> Other moisture-controlling interventions <input type="checkbox"/> Minor mold removal and remediation services <input type="checkbox"/> Ventilation improvements <input type="checkbox"/> Asthma-friendly cleaning products and supplies <input type="checkbox"/> Other interventions identified to be medically appropriate and cost effective	
<b>Eligibility Criteria</b>		
<p>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:</p> <p><input type="checkbox"/> An emergency department visit or hospitalization.            <b>OR</b>  <input type="checkbox"/> Two sick or urgent care visits in the past 12 months.            <b>OR</b>  <input type="checkbox"/> A score of 19 or lower on the asthma control test.</p>		
<b>Member Information</b>		
<b>Member name:</b>		<b>Date of birth (DOB):</b>
<b>Medi-Cal ID:</b>	<b>Phone number:</b>	<b>Preferred language:</b>
<b>Home address:</b>		
<b>Contact name:</b> (if different than member)		<b>Relationship:</b>
<b>Phone number:</b>		<b>Preferred language:</b>
<b>Member height:</b>		<b>Member weight:</b>
<b>Member's diagnosis (related to asthma remediation need):</b>		

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: \_\_\_\_\_