maryland physicians care
Medicaid with a Heart

Fax form to: 1-800-953-8856

Remote Patient Monitoring
Prior Authorization Form

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:
Asthma 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