



Asthma Remediation Approval Request Form

The Alameda Alliance for Health (Alliance) Asthma Remediation Approval Request Form is confidential. Filling out this form will help us better serve our members.

If you believe that your patient may be appropriate for asthma remediation services, please complete the form below. Approvals are based on member eligibility.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Attach a clinical summary and/or supporting documentation (i.e. clinic notes, hospital discharge summary, etc.), for asthma remediation services.
3. Please fax or email the completed form to the Alliance Community Supports Department at **1.510.995.3726** or **CSDept@alamedaalliance.org**.

For questions, please call the Alliance Case Management Department at **1.510.747.4512**.

PLEASE NOTE: Handwritten or incomplete forms may be delayed. Forms submitted without supporting information may also be delayed. **Final approval will occur after a home evaluation.**

SECTION 1: REQUESTING PROVIDER INFORMATION	
Full Name: _____	NPI: _____
Address: _____	City: _____ State: _____ Zip Code: _____
Phone Number: _____	Fax Number: _____
Email: _____	
Office Contact Name: _____	Date of Request: _____
Date of Service/Evaluation: _____	Order Attached <input type="checkbox"/>

SECTION 2: MEMBER INFORMATION	
Last Name: _____	First Name: _____
Date Of Birth (MM/DD/YYYY): _____	Alliance Member ID #: _____
Address: _____	
City: _____	State: _____ Zip Code: _____
Phone Number: _____	<input type="checkbox"/> Home <input type="checkbox"/> Cell

Patient's Qualifying Condition(s) (please select all that apply, must meet at least one (1) to be eligible):

- Patient was referred to Asthma Start by the Alliance
- Patient with poorly controlled asthma (please select all that apply):
 - Emergency Department (ED) visit or hospitalization in the past 12 months
 - Two (2) sick or urgent care visits in the past 12 months
 - Score of <20 on the Asthma Control Test
 - More than four (4) rescue inhaler refills in the past 12 months

Initial Request:

- Administrative Services

Supplemental Request – Environmental asthma trigger remediations request (please select all that apply):

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) filtered vacuum
- Dehumidifier
- Air filter
- Air purifier
- Asthma-friendly cleaning products and supplies
- Integrated pest management (IPM) services
- Minor mold removal and remediation services
- Ventilation improvements
- Other moisture-controlling interventions
- Other interventions identified to be medically appropriate and cost-effective*

***Please complete the patient evaluation below.**

Supporting Documents:

- Home visit has been conducted (please provide proof of home visit).
- Physician order has been attached/provided.

Patient Evaluation (please describe how and why the remediation(s) meets the needs of the individual):

Rendering Provider:

Asthma Start (NPI: 1568716181)

For Internal Use Only:

- No duplication
- Amount previously authorized (if applicable): _____
- Amount paid (if applicable): _____

Confirmed By: _____

Date: _____