# Community Supports – Asthma Remediation Approval Request Form

The Alameda Alliance for Health (Alliance) Community Supports (CS) Department – 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 CS 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 (ex. 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 ☐

## SECTION 2: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date Of Birth (MM/DD/YYYY): _____ Alliance Member ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

**Patient's Qualifying Condition(s)** (please select all that apply. The patient must meet at least one (1) qualifying condition to be eligible):

- ☐ Qualifying Diagnosis: _____
- ☐ Was referred over to Asthma Start by the Alliance
- ☐ Has 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

**Requesting Services:**

- ☐ Administrative services
- ☐ Asthma remediations services and supplies request (please see Physician Authorization form for more information)

**Supporting Documents:**

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

**Is the member currently linked to a case management team?**

- ☐ Yes, *please provide the name and phone number of the case manager or team*:

  _____
- ☐ No

**Is the member participating in or well-linked with other case management services?**

- ☐ Yes
- ☐ No

***Please describe the member's current case management situation:***

**For Patient Evaluation, please see the attached Physician Authorization form.**

**Rendering Provider**:

☐ Asthma Start (NPI: **1568716181**)

**For Internal Use Only:**

☐ No duplication

☐ Amount previously authorized (if applicable): _____

☐ Amount paid (if applicable): _____

Confirmed By:_____ Date: _____