Community Supports – Approval Request Form
(for Asthma Remediation)

The Alameda Alliance for Health (Alliance) Community Supports – Approval Request Form *(for Asthma Remediation)* 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: ☐ Yes

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

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

- ☐ Member was referred to Asthma Start by the Alliance
- ☐ Member 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

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 Documentation Checklist (all must be selected and submitted):

- ☐ Home visit has been conducted (please provide proof of the 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 (please select only one (1)):

- ☐ Asthma Start (NPI: 1568716181)
- ☐ Roots Community Health Clinic (NPI: 1083858823)

For Internal Use Only:

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

Confirmed By: _____ Date: _____