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# Humana At Home Referral Request Form

To refer a member to Humana At Home, please complete and return this form via a secure email process to HAH\_ProviderReferrals@humana.com or fax to 1-877-770-0651 using a fax coversheet.

1. **Member information**

|  |  |  |
| --- | --- | --- |
| **Humana member ID:** | **Member name:** | **Date of birth:** |
| **Referred by (name):** |
| **Referral source (physician’s office and contact information):** |

1. **Referral to service**

Identify to which service you would like to refer the Humana member by selecting the appropriate checkbox. If selecting “chronic condition,” select all conditions that apply, e.g., CHF, COPD, diabetes and/or CAD.

|  |  |
| --- | --- |
| [ ] [**Humana**](#CCM) **At Home Chronic Care Program (HCCP)**Who: Medicare Advantage members who are able to consent and able to participate in a health coaching model of care, have comorbidities and complex care management needs impacting ability to self-manage. | [ ] [**Specialty condition**](#SPC)Who: Members of all ages who have a physician confirmation of one of the following rare diseases: multiple sclerosis, myasthenia gravis, Parkinson’s disease, systemic lupus, rheumatoid arthritis (13 years and older), cystic fibrosis, scleroderma, hemophilia (except Von Willebrand disease), sickle cell disease, ALS, CIDP, polymyositis and dermatomyositis. |
| [ ] [**Chronic condition**](#CrCM) **(Select all that apply)**  |
| [ ]  CHF [ ]  COPD [ ]  Diabetes [ ]  CADWho: Members must be 18 years old or older, have one of the above chronic conditions and benefit from education about their condition, including coaching to improve self-management. |

1. **Criteria**

Please select “Yes” or “No” to the following criteria regarding the patient:

|  |  |
| --- | --- |
| Criteria  | Criteria met? |
| **Hospitalization** * Inpatient admissions within the last three months.

**or** * Two or more admissions in less than six months, related to the conditions for which the member is referred with complex care.
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| **Emergency room admission** * One or more emergency department visits in less than six months related to the condition(s) for which the member is referred.
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| **New diagnosis** * New diagnosis of chronic or specialty condition within the last year.
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## Complex care needs

## Please provide a brief description of the complex care needs applicable to the member whom you are referring.

|  |  |
| --- | --- |
| Need | Details |
| Caregiver |  |
| Self-care management skills |  |
| Depression/mental health/cognitive |  |
| Medications |  |
| Financial |  |
| Home safety/fall risk |  |
| Nutrition |  |
| Function |  |
| Transportation |  |
| Other |  |