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| **Shift Care Fax Information** |
| **To: Jefferson Health Plans/Health Partners Plans** **Shift Care Fax # (267) 515-6667** | **Requesting/ordering Provider Name:** Click or tap here to enter text. |
| **NPI #:** Click or tap here to enter text. |
| **Contact Name:** Click or tap here to enter text. | **Phone #:** Click or tap here to enter text. |
| **Date:** Click or tap to enter a date. | **Fax #:** Click or tap here to enter text. |

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| **Provider – Please Complete Area Below** |
| **Member Name:** Click or tap here to enter text. | **Member ID #:** Click or tap here to enter text. | **Member’s DOB:** Click or tap to enter a date. |
| **Level of care requested (Skilled Nursing or Home Health Aide):** Click or tap here to enter text.**What days are the service being requested for?** Choose an item.**How many hours of service are requested?** Click or tap here to enter text.**Why the number of hours requested is necessary?** Click or tap here to enter text.**What are the skilled health care needs? (G-tube feeds, vent care, TPN, etc)** Click or tap here to enter text.**What activities of daily living are hands on/ help needed for? (Bathing, dressing, toileting, ambulation, eating, or grooming)**Click or tap here to enter text.**Shift care/ Medical Day Care (MDC):** Click or tap to enter a date. |  |
| **Duration of Service (up to 6 months):** Click or tap here to enter text. |  |
| **Agency Name:** Click or tap here to enter text. | **Agency Contact #** Click or tap here to enter text. |
| **Agency NPI #:** Click or tap here to enter text. | **Agency Fax #** Click or tap here to enter text. |
| **ICD 10/Diagnosis:** Click or tap here to enter text. | [ ]  **New** [ ]  **Ongoing** [ ]  **Change (Increase/Decrease/Level of Care)** |

*Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.*

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| **Attached with Request** |  |
| [ ]  Letter of Medical Necessity (LOMN)  | [ ]  Recent Office Visit Notes (within the last 6 months) |
| [ ]  Head of Household (HOH) Work Verification Letter (letter should list days and hours worked). | [ ]  HOH Letter from their treating MD if disabled and not working. (letter must indicate HOH limitations and duration of limitations) |
| [ ]  School Schedule (if school aged) | [ ]  School Letter giving permission for services in school, if applicable |
| [ ] Autism Diagnostic Report | [ ]  Individualized Educational Plan (IEP) |
| [ ]  Recent signed Plan of Care (within 6 months) | [ ]  Nursing Notes  |
| [ ] Home Health Aide Logs |  |

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