

Adult Day Health Care (ADHC)

Purpose: To request prior authorization for ADHC services through the Nevada Medicaid program. Please see form [FA-17-I](#) on the [Providers Forms](#) webpage at www.medicaid.nv.gov for instructions for completing this form.

Required Attachments: The Universal Needs Assessment, the Physician Evaluation and the Service Plan must be submitted with this request. When faxing, please submit this page as the first page of the request packet.

Notes: Services are dependent on medical necessity and may be approved for a maximum of 1 year. If Hewlett Packard Enterprise needs additional information to make a determination for your request, you will be notified by mail and in the Provider Web Portal. You will have five business days to submit the requested information or the request will be denied for insufficient information (a "technical denial"). When complete information is submitted, Hewlett Packard Enterprise will make a determination within five business days and the authorization information will then be visible in the Provider Web Portal. Please do not re-fax unless you are directed to do so.

Please review the Billing Guidelines for Provider Type 39 available on the [Providers Billing Information](#) webpage.

Fax this form and the required attachments to: (855) 709-6846 **Questions? Call:** (800) 525-2395

DATE OF REQUEST: ____ / ____ / ____

REQUEST TYPE: Initial/New Continuing Revised Transfer

RECIPIENT INFORMATION	
Recipient Name:	Date of Birth:
Recipient ID:	Phone:
Mailing Address:	
Current Residence: <input type="checkbox"/> Independent Living <input type="checkbox"/> Group Care/Assisted Living <input type="checkbox"/> Other:	
ADHC FACILITY INFORMATION	
Name:	NPI:
Phone:	Fax:
Physical Address:	
Name and professional title of person completing this form:	
Contact Phone:	Contact Fax:
REQUESTED SERVICES	
Requested begin date of service:	Requested end date of service: <i>(Must be last day of the month)</i>
Requested number of days per week:	ICD-10 Code:
Choose one: <input type="checkbox"/> S5102 <i>(Attends 6 or more hours per day)</i> <input type="checkbox"/> S5100 <i>(Attends less than 6 hours per day or schedule varies between less than or more than 6 hours per day)</i>	
ADDITIONAL COMMENTS <i>(if applicable)</i>	
RECIPIENT VERIFICATION AND SIGNATURE	
<i>I am choosing to attend an Adult Day Health Care facility. If there is more than one facility in my area, I verify that I have been offered a choice of facilities.</i>	
Recipient Signature:	Date: