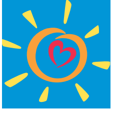


L.A. Care
HEALTH PLAN®

Environmental Asthma Trigger Remediation Service Authorization Request Form

Please fax completed document to 213-536-0634.

Environmental Asthma Trigger Remediations (hereinafter referred to as Asthma Remediation services) are for members with poorly controlled asthma. They are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. In order to start the request process, this form must be completed by a licensed healthcare provider who has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high cost services.

Required responses are identified with an asterisk.*

Name of Licensed Healthcare Provider (MD, DO, NP, PA) Authorizing Order

National Provider Identifier (NPI):* ________________ Phone Number:* ______________ Fax Number:* __________________

Provider Name:* ____ L.A. Care Provider ID: ________________________

Signature:* ____ Date:* ________________________

Name of Person Completing This Form (If Different from Above)

Organization/Agency Name :____

Requestor Name: ____

Requestor Address: ____

Requestor City: _____________________________ Zip Code: ____________________ Phone Number:___________________

☐ Check this box if you are an L.A. Care Asthma Remediation provider and are requesting to have the Member assigned to you.

Member Information

Member CIN Number:* ___________________ Date of Birth* ___________________ Phone Number:* ___________________

First Name:* _______________________________________ Last Name:* ____

Street Address:* ____

City:* ____ Zip Code:* ____

Parent/Authorized Representative Information (If Applicable)

First Name: ______________________________________ Last Name :____

Phone Number:__________________________________ Title/Relationship :_______________________________________

Member Eligibility Criteria*

Please select all that apply to the Member. At least one box must be selected.

☐ In the past 12 months, Member has had an emergency department visit with asthma-related symptoms.

☐ In the past 12 months, Member has had a hospitalization with asthma-related symptoms.

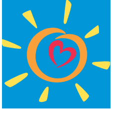
☐ In the past 12 months, Member has had two sick/urgent care visits.

☐ Member has a score of 19 or less on the Asthma Control Test.

☐ Checking this box simply attests that you have discussed treatment with the Member, and you have received the Member's consent to proceed with a Service Authorization Request (SAR) for covered benefits and services that require medical necessity review and approval prior to scheduling any appointment. *

Member Diagnosis

ICD-10 Code:* ____

 L.A. Care HEALTH PLAN®

Environmental Asthma Trigger Remediation Service Authorization Request Form

Please fax completed document to 213-536-0634.

In order for the Member to qualify for Asthma Remediation services, you must provide a current licensed healthcare provider's order with this form.

For Asthma Remediation Providers Only

Name of Asthma Remediation Provider/Organization: ____________________

Name of Person Completing this Form: ____________________ Phone Number: ____________

Email: ____________

Required responses are identified with an asterisk.*

Asthma Remediation services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver up to a total lifetime maximum of $7,500.[1] Asthma Remediation services are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household.[2] Asthma Remediation Services that is a physical adaptation to a residence must be performed by an individual holding a valid California Contractor's License that is in good standing. Please see the CSLB License Check Website for more information: **Check A License - CSLB (ca.gov)**

☐ Checking this box simply attests that you have discussed treatment with the Member, and you have received the Member's consent to proceed with a Service Authorization Request (SAR) for covered benefits and services that require medical necessity review and approval prior to scheduling any appointment.*

☐ Checking this box simply attests that the Member **IS NOT** receiving duplicative support from other State, local, or federally-funded programs.*

☐ Checking this box attests that a written evaluation describing how and why the remediation(s) meets the needs of the member has been completed and is in the member's file.*

Type of Service Authorization Request*

☐ **Initial**: The Member has not previously received Asthma Remediation services from L.A. Care or another health plan in California.

☐ **Continuation of Service**: The Member has previously received Asthma Remediation services from L.A. Care or another health plan in California.

If the Member has received Asthma Remediation services from another health plan in California, please specify which health plan(s) here: ____________________

Primary Location of Service

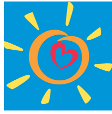
Street Address* ____________________

City* ____________________ Zip Code* ____________________

Secondary Location of Service (If Applicable)

Street Address: ____________________

City: ____________________ Zip Code: ____________________



L.A. Care HEALTH PLAN®

Environmental Asthma Trigger Remediation Service Authorization Request Form

Please fax completed document to 213-536-0634.

Type of Service

Quantity	Qualifying Item	Value to Not Exceed (Per Quantity)	Requested Amount
	Allergen-impermeable mattress dustcovers	$175	
	Allergen-impermeable pillow dustcovers	$17	
	High-efficiency particulate air (HEPA) filtered vacuums	$400	
	High-efficiency particulate air (HEPA) filters	$300	
	Integrated Pest Management (IPM) services	$600	
	De-humidifiers	$300	
	Air filters/Air cleaners	$300	
	Other moisture-controlling interventions	If this value exceeds $750, you must submit 2 bids.	
	Minor mold removal and remediation services[3]	$2,500	
	Ventilation improvements[3]	If this value exceeds $750, you must submit 2 bids.	
	Asthma-friendly cleaning products and supplies	Itemized receipt to be submitted upon claim submission.	
	Other interventions identified to be medically appropriate and cost-effective	Submit an invoice request. The home assessment must describe how and why the remediation(s) meets the needs of the individual.	
	Total Amount		

Name of Licensed Healthcare Provider (MD, DO, NP, PA) Authorizing Order

National Provider Identifier (NPI):* ________________ Phone Number* _______________ Fax Number* __________________________

Provider Name* ____ L.A. Care Provider ID ____________________________________

Signature* ____ Date* _________________________

1. If Member had previously received Asthma Remediation services and this is the second round of request, please include information explaining how the Member's condition has changed so significantly that additional modifications are necessary.
2. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
3. Asthma Remediation Providers must obtain written landlord approval before commencement of permanent physical home adaptations, and must notify the landlord and Member with written documentation that the modifications are permanent and that the State is not responsible for maintenance, repair, or removal of any modification if the Member ceases to reside at the residence.