

**Health Home Inquiry Form**

*Once form is completed, email it using secure email to:* [*SMHealthHomeInquiry@fideliscare.org*](mailto:SMHealthHomeInquiry@fideliscare.org)

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| Member Name: Member Fidelis ID: \*Member CIN:  Member DOB: / / \*Restriction Exemption Code:  HARP  Children’s HCBS  None  \*Health Home Care Management Agency:  Name of person submitting request: CMA Contact/Telephone #:  CMA Contact Email Address:  \*Lead Health Home:  \*Response needed from MCO:  Yes  No If yes, preferred response:  Email or  Phone |

**Select all that apply:**

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| Demographic Info (Phone, Address/Diligent Search Effort) | Recent Claims/Provider Data |
| Clinical Discussion with MCO Care Manager  Case management need:  BH or  Medical | QM project (POP, PIP, Gap in Care, etc.)  Identify: |
| Medicaid/DUAL POC Submission | PCS/CDPAS question |
| Health Home Admission Alert  Enrollment Date: | Health Home Discharge/Graduation Alert  Discharge Date: |
| Health Home Stepdown (*\*Attach discharge summary/POC)*  Outstanding care management needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |