

**Health Home Inquiry Form**

*Once form is completed, email it using secure email to:* *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 ManagerCase 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 AlertDischarge Date:  |
| [ ]  Health Home Stepdown (*\*Attach discharge summary/POC)*Outstanding care management needs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |