HEAVENLY HEALTH CARE

Medicaid Plan of Care for Texas In-Home Telemonitoring

Patient Information

Patient Name:_____DOB:_____Gender: M / F

SS Number:_____Medicaid Number_____ (MQMB)

Address:_____City_____State_____Zip _____

Phone Number: (Home)_____(Other) _____

Doctors Information

Physician Name:_____NPI #: _____

Address:_____City_____State_____Zip _____

Physician Medicaid # _____

Phone Number:_____Fax _____

Plan of Care Data

Start Date_____End Date_____Specific Diagnosis Code for (DM) or (HTN) _____

RPM Frequency (1x60) Other _____ Procedure Code _____

Risk Factors

- ☐ Two or more Hospitalizations in the prior 12- month period
- ☐ Frequent or recurrent emergency department visits
- ☐ Documented history of poor adherence to ordered medication regimens documented
- ☐ history of falls in the prior 6-month period
- ☐ Limited or absent support systems
- ☐ Living alone or being home alone for extended periods of time
- ☐ Documented history of care access challenges

Default Vital Sign Parameters unless modified by attending Physician:

☐ BP 160/90 – 90/60
☐ BS >350 or <60

☐ BP _____/_____ – _____/_____
☐ BS >_____or <_____

I certify that this patient has met all of the Texas Medicaid requirements for Home Telemonitoring Services, and the patient has a medical need for these services. The patient is under my care, and I have authorized these services on the plan of care and will periodically review the plan.

Physician's Signature

_____ Date _____

Please contact HEAVENLY HEALTH CARE with any questions at Phone: (956) 271-4755

Fax to: (956) 598-5098