Simple Medicaid **PLAN OF CARE** for Texas In-Home Telemonitoring

Patient Information

Patient Name: ______________________________ DOB: _________________ Gender: M or F

SS Number: _______________________ Medicaid Number: _____________________ **(MQMB ONLY)**

Address: ___________________________________ City: ___________________ ST: TX Zip: ______

Phone Number (Home): _______________________________ (Other): __________________________

Mental Status: ___ Normal ___ Forgetful ___Disoriented

Doctors Information

Physician's Name: __________________________________ NPI #: ____________________________

Address: _______________________________City ________________________ST: TX Zip: _______

UPIN Number: _________________________ Physician Medicaid #: ___________________________

Phone Number: _____________________________________ Fax: ____________________________

Plan of Care Data

Start Date: ________ End Date: ____________ Specific Diagnosis Code for (DM) or (HTN): ____________

RPM Frequency (1X60) Other: ________________________________

Risk Factors ***Must check two or more to be eligible**.

__ Two or more Hospitalization in the prior 12-month period
__ Frequent or recurrent emergency department visits
__ Documented history of poor adherence to order medication regimens documented
__ History of falls in the prior 6-month period
__ Limited or absent informal 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	BP >______/______or<_______/______
BS >350 or <60	BS >_____________or<_______________
Pulse >100 or <60	Pulse >___________ 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
Sign Here ____ Date: ___________________________

Please forward a copy of this document to your RPM provider in order to initiate Reimbursement!