



Asthma Trigger Remediation Form

Please submit form and receipts/POs with the treatment authorization request (TAR).

Asthma trigger remediations (also referred to as asthma remediation services) are for members with poorly controlled asthma. They are minor to moderate 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.

***Required responses are identified with an asterisk.**

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. Indicate date performed:
- Member has a recommendation from a licensed health care provider who has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, and/or other high-cost services.

If a box above is NOT checked, STOP. Member does not meet eligibility criteria. If box is checked, move on to next section.

- 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 TAR for covered benefits and services that require medical necessity review and approval prior to scheduling appointment.*

Name of Person Completing This Form

Organization/Agency Name:* _____ Date:* _____

Organization/Agency National Provider Identifier:* _____

Referring Individual’s Name:* _____

Referring Individual’s Email:* _____

Referring Individual’s Phone Number: * _____

Referring Individual’s Relationship to Member: *

- Medical Provider
- Social Services Provider
- Member/Family
- Other: _____



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Name of Asthma Remediation Provider Organization: * _____

Name of Person Completing this Form: * _____

Phone Number: * _____ Email: * _____ Date: * _____

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. 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. Asthma remediation services that are physical adaptations to a residence must be performed by an individual holding a valid California contractor's license that is in good standing. Please see the [Contractor's State License Board's website](#) for more information.

- 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 TAR for covered benefits and services.*
- 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 Partnership or another health plan in California.
- Continuation of Service:** The member has previously received asthma remediation services from Partnership 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: * _____



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Type of Service

Qty	Qualifying Item	Value to Not Exceed (Per Qty)	Requested Amount	Approved Amount
	Allergen-impermeable mattress dustcovers	\$175		
	Allergen-impermeable pillow dustcovers	\$20		
	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	submit quote/invoice for authorization		
	Minor mold removal and remediation services ³	\$2,500		
	Ventilation improvements ³	submit quote/invoice for authorization		
	Asthma-friendly cleaning products and supplies	\$600/year on a 1 year TAR		
	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.		
	Administration rate			
	Shipping			
	Tax			
	Total Amount (not to exceed \$7500)			

1. If member had previously received asthma remediation services and this is the second round of requests, 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. Must be submitted with TAR.
4. On a case by case basis, qualifying item maximum amounts may be approved above defined price cap on a exception basis, not to exceed total lifetime benefit maximum of \$7,500.