Telemonitoring Authorization Form

Instructions

1. Schedule an office visit to review the telemonitoring program with the member and obtain his or her consent to join.
2. Complete all areas of the form below.
3. Sign the form and obtain the member's signature.
4. Submit the completed form to the Critical Signal Technology Care Center at 1-800-325-5145.

Member Information	
Member name	Amerigroup Member ID
Date of birth	Male / Female (circle one)
Address	City
	State ZIP
Home phone Cell phone	Email
Current living situation: ☐ Alone ☐ With family ☐ Caregiver ☐ Other:_____	
Emergency contact name	Relationship
Address	Phone

Disease Diagnosis (The member must have at least one required diagnosis to be eligible for this program)

☐ Chronic obstructive pulmonary disease ☐ Diabetes ☐ Congestive heart failure ☐ Hypertension

Please add any additional diagnoses we should be aware of:

_____

Equipment Recommended (check all that apply)

☐ Weight scale ☐ Small blood pressure cuff ☐ Regular blood pressure cuff ☐ Large blood pressure cuff ☐ SpO2 ☐ Glucometer

All critical readings will be reported immediately after being verified as a true reading by the Critical Signal Technologies-LTL Care Center Operator, using the protocol below. Vital signs that are outside the parameter but not critical will be reported after the third consecutive day out of parameter reading, unless otherwise specified below.

Comments_____

_____

Critical Minimums/Maximums Table

Measurement	Min	Max
Heart rate/pulse	50	120
Blood pressure, systolic	105	180
Blood pressure, diastolic	46	90
Glucose/blood sugar	70	300
Weight	3 lbs. gained in 24 hours 5 lbs. gained in 5–7 days	3 lbs. lost in 24 hours 5 lbs. lost in 5–7 days
SpO2	Less than 88 with shortness of breath	

Specific Parameters for Individual Patient

Measurement	Min	Max
Heart rate/pulse		
Blood pressure, systolic		
Blood pressure, diastolic		
Glucose/blood sugar		
Weight	3 lbs. gain	3 lbs. loss
SpO2		

Physician Information	
Physician name	
Address	City
	State ZIP
Phone Fax	Email
Physician Specialist Information	
Physician specialist name	
Address	City
	State ZIP
Phone Fax	Email
After-hours Contact Information	
Provider contact name	
Phone Fax	
Nurse contact name	
Phone Fax	

Does the patient consent to participate in telemonitoring services offered by CST? ☐ Yes ☐ No

Does physician agree to review the member's vital reports weekly? ☐ Yes ☐ No

Physician signature_____Date____/____/____

Member signature_____Date ____/____/____

Member's representative signature_____Date____/____/____

For CST Use Only

☐ Documents Received: Physician/signature

☐ HIPAA Form

☐ Training Sheet