• **Case Creation in Atrezzo Portal**
  – Requires a questionnaire for:
    • Skilled Nurse Visits
    • Home Health Aide Visits.
At the end of your request, there is a step for a questionnaire.

<table>
<thead>
<tr>
<th>QUESTIONNAIRES</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire Name</td>
<td></td>
</tr>
<tr>
<td>Home Health Plan of Care: HHA and Skilled Nurse Visits</td>
<td>Not Completed</td>
</tr>
</tbody>
</table>

- Patient Detail
- Requesting Provider
- Service Provider
- Attending Physician
- Service Detail
- Procedures
- Diagnoses
- Clinical Information
- Attached Documents

**Questionnaires**
If you try to submit your request without completing the questionnaire, you will receive an error message.
Please click on the title of the questionnaire to begin.
The questionnaire will open. You will need to answer all questions. You may save changes or return to the request if needed.

Edit Questionnaire

Home Health Plan of Care

1. What type of request are you entering for this recipient?
   (Please select one.)
   - Initial, short term, 45 days of less
   - Initial, long term, 46 days or more
   - Re-certification, ongoing request
   - Change of condition, change of plan, or change of types of authorized services (explain)

2. Is the recipient on any of the following medications?
   (Please select between 1 and 4 items.)
   - IV Medications
   - Injectable Medications
   - Oral Medications
   - Other
   - N/A; not on any medications

3. Medication Management
   (Please select one.)
Some of the selections you make, will populate further questions for response.

2. Is the recipient on any of the following medications?

(Please select between 1 and 4 items.)

- [ ] IV Medications
- [ ] Injectable Medications
- [ ] Oral Medications
- [ ] Other
- [ ] N/A; not on any medications

2.1.1. Please list the name, doses and frequency for each IV medication.

2.1.2. Have any been prescribed within 30 days of the start date of this CERT period?

(Please select one.)

- [ ] Yes
- [ ] No

2.1.3. Was there a dosage change for any of the medications?

(Please select one.)

- [ ] Yes
- [ ] No
Some of the questions may allow multiple answers with additional questions that appear. This example wants you to describe the contracture (6.3.1) and the endurance (6.6.1). The second number corresponds to where the item is in the list.
• You may save your changes at any time and return to the request later to finish and submit.
• Once you have completed the questionnaire, click the “mark as completed” button. You will not be able to modify once you do this.
Thank you!