

# HOME HEALTH CARE INITIAL AUTHORIZATION FORM

PLEASE FAX THIS FORM ALONG WITH THE REQUIRED INFORMATION TO: **866-996-0077**

Questions? Call **833-585-6262**

<b>Date of Request:</b> _____	<b>Standard Request:</b>	<b>Retro Request:</b>	<b>Urgent Request:</b>																																				
<p>Note: Expedited organization determinations (urgent requests) can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (See CMS regulation: 40.8)</p>																																							
<b>All Information Required to Process Request in a Timely Manner</b>																																							
<p style="text-align: center;"><b><u>Member Information</u></b></p> <p>Name: _____</p> <p>DOB: _____</p> <p>State of Residence: _____</p> <p>Member ID #: _____</p> <p>Health/Benefit Plan ID: _____</p> <p>*Homebound?    Yes            No</p> <p>Able/Willing/Teachable Caregiver:    Yes            No</p> <p>If no, please explain: _____</p>		<p style="text-align: center;"><b><u>Diagnosis Information</u></b></p> <p>Primary Diagnosis &amp; Code: _____</p> <p>Secondary Diagnosis &amp; Code: _____</p> <p>Tertiary Diagnosis &amp; Code: _____</p> <p>Quaternary Diagnosis &amp; Code: _____</p> <p>HIPPS Code: _____</p> <p>Date of D/C from Facility or Office Visit: _____</p> <p>Home health care already started?    Yes            No            Unknown</p> <p>Start of Care Date: _____    Not Applicable</p>																																					
<p style="text-align: center;"><b><u>Referral Information</u></b></p> <p>Source:    Hospital            MD Office            SNF/Rehab</p> <p>Provider: _____</p> <p>NPI: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>		<p style="text-align: center;"><b><u>Ordering Information</u></b></p> <p>Provider: _____</p> <p>NPI: _____</p> <p>Phone: _____</p> <p>Fax: _____</p>																																					
<p style="text-align: center;"><b><u>Review Period A (first 30 Days): Requested Number of Visits</u></b></p> <p style="text-align: right;">Visits Requested:    Date of First Visit:</p> <table style="width: 100%;"> <tr> <td>Skilled Nursing</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Physical Therapy</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Occupational Therapy</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Speech Therapy</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Home Health Aide</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Medical Social Work</td> <td>_____</td> <td>_____</td> </tr> </table>		Skilled Nursing	_____	_____	Physical Therapy	_____	_____	Occupational Therapy	_____	_____	Speech Therapy	_____	_____	Home Health Aide	_____	_____	Medical Social Work	_____	_____	<p style="text-align: center;"><b><u>Primary Subtype (select one)</u></b></p> <table style="width: 100%;"> <tr> <td>B-12</td> <td>Ostomy</td> <td>Neuromuscular Maintenance</td> </tr> <tr> <td>UTI</td> <td>General</td> <td>Neuromuscular Restorative</td> </tr> <tr> <td>CHF</td> <td>Diabetes</td> <td>Total Hip Replacement</td> </tr> <tr> <td>COPD</td> <td>Heart Surgery</td> <td>Total Knee Replacement</td> </tr> <tr> <td>CVA</td> <td>Wound Care</td> <td>Chemotherapy</td> </tr> <tr> <td>Sepsis</td> <td>Wound Vac</td> <td>Foley Catheter</td> </tr> </table>		B-12	Ostomy	Neuromuscular Maintenance	UTI	General	Neuromuscular Restorative	CHF	Diabetes	Total Hip Replacement	COPD	Heart Surgery	Total Knee Replacement	CVA	Wound Care	Chemotherapy	Sepsis	Wound Vac	Foley Catheter
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<p style="text-align: center;"><b><u>Required Information</u></b></p> <p>At least ONE of the following is required:</p> <p style="text-align: center;">H&amp;P</p> <p style="text-align: center;">Inpatient Discharge Summary</p> <p style="text-align: center;">Notes from Hospital or SNF</p> <p style="text-align: center;">MD Office Notes</p> <p style="text-align: center;">Wound Care Notes &amp; Measurements</p>		<p style="text-align: center;"><b><u>Home Health Preference</u></b></p> <p>Provider: _____</p> <p>Phone: _____</p> <p>Requestor Email: _____</p> <p>Branch NPI: _____</p> <p>Fax: _____</p> <p>Network:    OCHN            CSI            Northcoast            Carelon</p>																																					
<p><b>*CMS Definition:</b> Homebound status certified by MD; there is a normal inability to leave home and leaving the home is a considerable and taxing effort.</p>																																							
<p><b>CONFIDENTIALITY NOTICE:</b> This fax message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or may otherwise be protected by law. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by fax and destroy all copies of the original message and any attachment thereto.</p>																																							