



FOR FASTER AUTHORIZATIONS, PLEASE VISIT:
<https://providers.carelonmedicalbenefitsmanagement.com/postacute/>

HOME HEALTH CARE RE-AUTHORIZATION FORM

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

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

Date of Request: _____	Standard Request:	Retro Request:	Urgent Request:
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)			
All Information Required to Process Request in a Timely Manner			
Member Information Name: _____ DOB: _____ State of Residence: _____ Member ID #: _____ Health/Benefit Plan ID: _____ Able/Willing/Teachable Caregiver: Yes No If no, please explain: _____		Agency Information Agency: _____ Name: _____ Email: _____ NPI: _____ Phone: _____ Fax: _____	
Residence Information Private Residence: _____ Assisted Living: _____ Independent Living: _____ Long Term Care: _____ Other: _____		Diagnosis Information Primary Diagnosis & Code: _____ Secondary Diagnosis & Code: _____ Tertiary Diagnosis & Code: _____ Quaternary Diagnosis & Code: _____ HIPPS Code: _____	
Authorization Information Auth Number: _____ Start of Care Date: _____		Physician Information Following/Plan of Care/NP: _____ NPI: _____ Phone: _____ Fax: _____	
Agency Request Certification Period: From _____ To _____ 30-Day Review Period (make selection): A or B			
Discipline	Date of Last Visit	Number of Visits Requested	Plan of Care Frequency
Skilled Nursing	_____	_____	_____
Physical Therapy	_____	_____	_____
Occupational Therapy	_____	_____	_____
Speech Therapy	_____	_____	_____
Home Health Aide	_____	_____	_____
Medical Social Work	_____	_____	_____
Required Checklist: The items below are required for the review process. Please submit this completed form along with the listed requirements. 1. Verbal or signed order (including frequency and duration to cover requested visits) if a new skill is being requested OR if not submitted with initial request. 2. Completed signed SOC OASIS for first reauthorization request. 3. Updated clinical documentation (completed ROC OASIS, signed 485/POC) for all services being requested. Along with all visit notes, ensure the evaluation is being or has been submitted. 4. Provide wound measurements from previous visits - if applicable for wound care.			
CMS Definition: Homebound status certified by MD; there is a normal inability to leave home and leaving the home is a considerable and taxing effort.			
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