



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: **844-834-2908**

Questions? Call **844-411-9622**

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			
<u>Member Information</u> Name: DOB: State of Residence: Member ID #: Health/Benefit Plan ID: Able/Willing/Teachable Caregiver: Yes ☐ No ☐ If no, please explain:		<u>Agency Information</u> Agency: Name: Email: NPI: Phone: Fax:	
<u>Residence Information</u> Private Residence: Assisted Living: Independent Living: Long Term Care: Other:		<u>Diagnosis Information</u> Primary Diagnosis & Code: Secondary Diagnosis & Code: Tertiary Diagnosis & Code: Quaternary Diagnosis & Code: HIPPS Code:	
<u>Authorization Information</u> Auth Number: Start of Care Date:		<u>Physician Information</u> Following/Plan of Care/NP: NPI: Phone: Fax:	
<u>Agency Request</u>			
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.			
CONFIDENTIALITY NOTICE: 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.			