carelon

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

HOME HEALTH CARE INITIAL 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: _____
*Homebound? Yes ☐ No ☐
Able/Willing/Teachable Caregiver: Yes ☐ No ☐
If no, please explain: _____

Diagnosis Information

Primary Diagnosis & Code: _____
Secondary Diagnosis & Code: _____
Tertiary Diagnosis & Code: _____
Quaternary Diagnosis & Code: _____
HIPPS Code: _____
Date of D/C from Facility or Office Visit: _____
Home health care already started? Yes ☐ No ☐ Unknown ☐
Start of Care Date: _____ Not Applicable ☐

Referral Information

Source: Hospital ☐ MD Office ☐ SNF/Rehab ☐
Provider: _____
NPI: _____
Phone: _____
Fax: _____

Ordering Information

Provider: _____
NPI: _____
Phone: _____
Fax: _____

Review Period A (first 30 Days): Requested Number of Visits

	Visits Requested:	Date of First Visit:
Skilled Nursing		
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Home Health Aide		
Medical Social Work		

Primary Subtype (select one)

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 ☐

Required Information

At least ONE of the following is required:

H&P
Inpatient Discharge Summary
Notes from Hospital or SNF
MD Office Notes
Wound Care Notes & Measurements

Home Health Preference

Provider: _____
Phone: _____
Requestor Email: _____
Branch NPI: _____
Fax: _____
Network: OCHN ☐ CSI ☐ Northcoast ☐ Carelon ☐

***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.