

HOME HEALTH CARE INITIAL AUTHORIZATION FORM

PLEASE FAX THIS FORM ALONG WITH THE REQUIRED INFORMATION TO: **844-834-2908**

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							
<u>Member Information</u>				<u>Diagnosis Information</u>			
Name: _____				Primary Diagnosis & Code: _____			
DOB: _____				Secondary Diagnosis & Code: _____			
State of Residence: _____				Tertiary Diagnosis & Code: _____			
Member ID #: _____				Quaternary Diagnosis & Code: _____			
Health/Benefit Plan ID: _____				HIPPS Code: _____			
*Homebound? Yes ☐ No ☐				Date of D/C from Facility or Office Visit: _____			
Able/Willing/Teachable Caregiver: Yes ☐ No ☐				Home health care already started? Yes ☐ No ☐ Unknown ☐			
If no, please explain: _____				Start of Care Date: _____ Not Applicable ☐			
<u>Referral Information</u>				<u>Ordering Information</u>			
Source: Hospital ☐ MD Office ☐ SNF/Rehab ☐				Provider: _____			
Provider: _____				NPI: _____			
NPI: _____				Phone: _____			
Phone: _____				Fax: _____			
Fax: _____							
<u>Review Period A (first 30 Days): Requested Number of Visits</u>				<u>Primary Subtype (select one)</u>			
Visits Requested: _____ Date of First Visit: _____							
Skilled Nursing _____				B-12 ☐ Ostomy ☐ Neuromuscular Maintenance ☐			
Physical Therapy _____				UTI ☐ General ☐ Neuromuscular Restorative ☐			
Occupational Therapy _____				CHF ☐ Diabetes ☐ Total Hip Replacement ☐			
Speech Therapy _____				COPD ☐ Heart Surgery ☐ Total Knee Replacement ☐			
Home Health Aide _____				CVA ☐ Wound Care ☐ Chemotherapy ☐			
Medical Social Work _____				Sepsis ☐ Wound Vac ☐ Foley Catheter ☐			
<u>Required Information</u>				<u>Home Health Preference</u>			
At least ONE of the following is required:				Provider: _____			
H&P				Phone: _____			
Inpatient Discharge Summary				Requestor Email: _____			
Notes from Hospital or SNF				Branch NPI: _____			
MD Office Notes				Fax: _____			
Wound Care Notes & Measurements				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.							
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