

HOME HEALTH CARE AUTHORIZATION REQUEST FORM

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

Questions? Call 833-585-6262

Date of Request:	Standard Request: <input type="checkbox"/> Retro Request: <input type="checkbox"/>	Urgent Request: <input type="checkbox"/> 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)
Member Name: _____ DOB: _____ Member ID# (Required): _____ Member State of Residence: _____ Health/Benefit Plan ID: _____	Agency(required): _____ NPI (required): _____ Requestor Name(required): _____ Requestor Email(required): _____ Phone(required): _____ Fax(required): - _____	
AUTHORIZATION NUMBER: _____ Start of Care Date: (required): _____	Able/willing/teachable caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____	

Following/Plan of Care Physician/NP (required): _____ **Phone:** _____
NPI (required): _____ **Fax:** _____

Diagnosis:	Code	Description	HIPPS CODE:	Residence:
Primary			<input type="checkbox"/> _____	<input type="checkbox"/> Private Residence
Secondary				<input type="checkbox"/> Assisted Living
Tertiary				<input type="checkbox"/> Independent Living
Quaternary				<input type="checkbox"/> Long Term Care
				<input type="checkbox"/> Other: _____

Agency Request: (Filling out the dates and grid below are required):
Certification Period dates? From: _____ **To:** _____ **(must match Plan of Care date range) From:** _____ **To:** _____

Discipline	If discipline was previously approved, what date was the last visit used?	# Visits being requested	From	To (may not request past cert period end date)	Frequency on Plan of Care
<input type="checkbox"/> SN					
<input type="checkbox"/> PT					
<input type="checkbox"/> OT					
<input type="checkbox"/> ST					
<input type="checkbox"/> HHA					
<input type="checkbox"/> MSW					

REQUIRED CHECKLIST: The 3 requirements listed below are required for the review process. Please submit this completed form along with the listed requirements.

1. Verbal or Signed order if a new skill is being requested.
2. For the first Re-Authorization request please submit the completed OASIS.
3. Updated clinical documentation for all services being requested. Along with all visit notes, please ensure the evaluation is being or has been submitted.

**** Wound Care- provide wound measurements from previous visits**

Comments/ Notes: _____

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