carelon

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

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:** ☐ **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)**
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?** ☐**Yes** ☐**No** **If no, please explain:**
Following/Plan of Care Physician/NP (required):_____**Phone:** **NPI (required):** **Fax:**		

Diagnosis:	Code	Description	HIPPS CODE:	Residence:
Primary			☐ _____	☐ Private Residence
Secondary				☐ Assisted Living
Tertiary				☐ Independent Living
Quaternary				☐ Long Term Care
				☐ 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
☐ SN					
☐ PT					
☐ OT					
☐ ST					
☐ HHA					
☐ 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 hasbeen submitted.

** Wound Care- provide wound measurements from previous visits

Comments/ Notes: