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

carelon

HOME HEALTH CARE AUTHORIZATION REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH 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)

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:

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