Prior Authorization Form
Home Health Request

Phone: 1-800-521-6622 | Fax: 1-866-755-9982

Contact name:

Phone number: Fax number:

Member information		
Member name:		Member ID number:
Date of birth:	Member's phone number:	
Authorization number, if applicable:		
Primary insurance? ☐ Yes ☐ No	Name of carrier:	
Primary insurer member ID:	Primary authorization number:	

Provider information	
Ordering physician name:	Physician NPI:
Physician phone number:	Physician fax number:
Home care company:	Provider NPI:
Home care company phone number:	Home care company fax number:

Codes
Primary ICD diagnosis code:
Description:

Home health service requested

THE FIRST SIX SN/PT/OT/ST and HHA VISITS PER CALENDAR YEAR DO NOT REQUIRE AN AUTHORIZATION.

	Billing code	Date of 6th visit	Requested dates of service	Number of requested visits
Skilled nursing				
Physical therapy				
Occupational therapy				
Speech therapy				
Home health aide				
Social worker				

CLINICAL NOTES TO SUPPORT THE MEDICAL NEED OF THIS SERVICE ARE REQUIRED.

ALL FIELDS MUST BE COMPLETED FOR REQUEST TO BE PROCESSED.