

UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM

NOTE: THIS FORM IS NOT TO BE USED FOR PCA SERVICES.

*This area is to be left blank so that health plans can insert their own logo, telephone # and fax #. This form will only be available for health plans and CBP organizations. It is not to be used for DHS FFS.*

*The 5 health plans have indicated they are able to put a link on their Web site so that providers can access it there. Health plans are in various stages of systems programming to create a fillable PDF form. At this time, however, providers must still send these forms to the health plans via facsimile.*

PLEASE NOTE: This form is NOT to be used for DHS FFS Home Health Services. It is to be used ONLY for Home Health Services covered by a health plan or a county-based purchasing plan.

In addition, this form is NOT to be used for PCA services. It is to be used ONLY for Home Health Services.

Date: \_\_\_\_\_ Start of Care Date: \_\_\_\_\_

**Initial Authorization: Y/N Continued Authorization: Y/N**

**Patient Information**

Name: \_\_\_\_\_ Member Ins. ID: \_\_\_\_\_

**Permanent Home**

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Servicing address** (if patient is at a different address): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Group # \_\_\_\_\_

DOB: \_\_\_\_\_

**Primary Diagnosis for Home Care Services and ICD-10 Codes:** \_\_\_\_\_

**Other/Comorbid Diagnosis and ICD-10 Codes:** \_\_\_\_\_

**Homebound:** Y/N

**Location of Service:** Member Home \_\_\_ Assisted Living \_\_\_ Group Home \_\_\_ Foster Care \_\_\_ Customized Living \_\_\_

Other: \_\_\_\_\_

**Home Care Agency Information**

Agency Name: \_\_\_\_\_ NPI: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Contact Fax: \_\_\_\_\_

