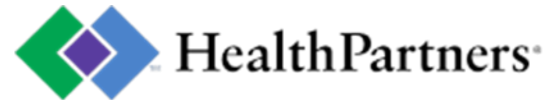
UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM

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



Please Fax To (952)853-8712
For Questions Call (952)883-6333

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: Yes No

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: ____________________________

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MD/Ordering Provider Information

Name: ____________________________________ NPI: ________________________ Clinic: ____________________

Clinic Address:____ City, State, Zip_______________________________

Clinic/MD Contact Phone Number: ____________________________ Fax number: ______________________________

Date of last appointment: __________________________ Next visit date (If known):_____________________________

Service Request Information:

Type of Service	Procedure Code	Number of Visits Requested	Frequency	Start Date (this request)	End Date (this request)

Clinical Information/Summary/Comments: [NOTE: Please attach the current CMS 485/Home care plan of care and clinical notes to support authorization request along with request.]

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Recent Hospitalization/Surgery: _______________________________________ D/C Date: _______________________