

Home Care Authorization Request Form for Advantage MD, EHP, Priority Partners (PP) and USFHP

Note: All fields are mandatory. Clinical/Chart notes are required and must be faxed with this request. EHP and PP Outpatient Medical FAX: 410-762-5205. USFHP Outpatient FAX: 410-424-2603. Advantage MD Outpatient Medical FAX: 855-704-5296. Incomplete requests will be returned.

PATIENT INFORMATION:

Patient Name:	DOB:
Patient Address:	Member ID#
Requesting Provider/Facility:	Primary Care Physician
Diagnosis:	

SERVICING PROVIDER INFORMATION:

Provider:	Address:
NPI#	
TIN#	Phone:
Comments:	Pre-service Post-service

HOME HEALTH CARE REQUEST INFORMATION

FOR NEW EPISODE OF CARE please complete	FOR EXTENSION OF SERVICES please complete- CURRENT auth #:
SOC date:	End date _____
Is there a previous auth on file? <input type="checkbox"/> YES <input type="checkbox"/> NO	# Visits used to date ___ SNV ___ PT ___ OT
If yes please provide auth # and d/c date	___ ST ___ HHA ___ MSW
SNV HCPCS CODE _____ x # of visits _____ from (date) _____ to (date) _____	Requesting Additional
PT CODE _____ x _____ from _____ to _____	SNV CODE _____ x _____ from _____ to _____
OT CODE _____ x _____ from _____ to _____	PT CODE _____ x _____ from _____ to _____
ST CODE _____ x _____ from _____ to _____	OT CODE _____ x _____ from _____ to _____
HHA CODE _____ x _____ from _____ to _____	ST CODE _____ x _____ from _____ to _____
MSW CODE _____ x _____ from _____ to _____	HHA CODE _____ x _____ from _____ to _____
	MSW CODE _____ x _____ from _____ to _____

DATES OF MOST RECENT NOTES ATTACHED:

CLINICAL COMMENTS:

REQUIRED REQUESTOR INFORMATION

Contact Name (who can provide /discuss addt'l info):
Contact Phone:
Contact Fax: