Home Health Prior Authorization Form

Fax Form To: **313.748.1312**

Recent documentation and physician orders are needed to support the request for visits. Please complete all fields to ensure timely processing.

Member name: ______________________ THC ID #: ____________ DOB: ____________

Ordering physician: ______________________ Home care Dx: ______________________

HHC agency: ______________________ Tax ID #: ______________________

HHC contact: ______________________ NPI: ______________________

Auth start date: ______________________ Phone: ______________________

Auth end date: ______________________

1. Is member homebound? ☐ Yes ☐ No ______________________
   (reason home care is best place for services, i.e. SN home infusion)
2. If RN Daily – Estimated date daily visits to end: ______________________ ☐ N/A
3. Visits Requested:
4. Primary Focus of Care for each discipline:
   (wound/catheter care, gait training, ADL/IADL, feeding/swallow therapy, community resources/ placement, nutrition education, etc.)

RN: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

PT: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

OT: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

ST: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

MSW: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

HHA: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

RD: Frequency: ____________ ______________________
Time(s) per: ☐ day ☐ wk ☐ mo

5. Additional information to support the authorization request:

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THC form ID: ____________