***Advanced Health***
***289 LaClair St, Coos Bay, OR 97420***
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

# Home Health Authorization Request

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•

**** PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS ****

**Member's primary health insurance: Advanced Health OHP ☐ Dual Eligible - has Medicare and Advanced Health OHP ☐**

Member Name: _____ Member ID #: _____ DOB: _____/_____/_____

Home Health Provider: _____ PCP: _____

ICD-10 Code(s):_____ Diagnosis(es):_____

*Required

Certification Period *: From _____/_____/_____ to _____/_____/_____

| Level of Care | # of Visits | Date Range |
|---|---|---|
| ☐ Physical Therapy Visit (R421) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Occupational Therapy Visit (R431) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Home Health Aide Visit (R571) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Skilled Nursing Visit (R551) | | _____/_____/_____ to _____/_____/_____ |

Plan of Treatment (If you need more room for explanation, please submit extra page):

_____

Person Completing Form: _____ Fax: _____ Phone: _____

Signature of Requesting Provider: _____ Date: _____/_____/_____

**Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and Advanced Health as applicable.**

**For Internal Use Only:** ***Disposition of Authorization:*** ☐ Approved

| Level of Care | # of Visits | Date Range |
|---|---|---|
| ☐ Physical Therapy Visit (R421) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Occupational Therapy Visit (R431) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Speech-language Pathology Visit (R441) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Skilled Nursing Visit (R551) | | _____/_____/_____ to _____/_____/_____ |
| ☐ Home Health Aide Visit (R571) | | _____/_____/_____ to _____/_____/_____ |

Medical Management Staff Signature: _____ Date: _____/_____/_____

☐ **Modified Request:** _____

Medical Management Staff Signature: _____ Date: _____/_____/_____

Faxed via: System _____ Manual _____

☐ **Denial Reason**

☐ Patient not eligible ☐ Requested information not received ☐ Retro authorization (criteria not met)

☐ Other: _____

Medical Directors Signature (For Denied Services): _____ Date: _____/_____/_____

D PII MC Date: _____/_____/_____ NOA Date: _____/_____/_____ Initials: _____

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# Instructions to Complete
# Home Health Authorization Request

- Requesting Provider is responsible to submitting all information in the top area of the form.
- Authorization requests must be accompanied with a signed Plan of Treatment/Evaluation. (Note: a current signed Prescribing Physician's prescription must be on file at the Home Health Agency's office for review upon request by Health Plan.)
- Follow-up requests for continuation of existing services must be made prior to expiration of current certification period.
- Recertification is required every 60 days from the initiation of treatment.
- Fax completed form, signed Plan of Care, and any other pertinent documentation to Health Plan's Medical Management Department at (541) 269-7147.
- If you have questions regarding this form or other related questions, please contact Health Plan's Medical Management Department at (541) 269-7400.
- Disclaimer: Approval does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare, Advanced Health as applicable.

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**To complete form, please follow these instructions:**

| | |
|---|---|
| **Member Name:** | Enter the full name of the Advanced Health Member, including middle initial, if known |
| **Plan ID#:** | (**Required field**) Enter the Member's ID# |
| **DOB:** | (**Required field**) Enter the Member's date of birth |
| **Home Health Provider:** | Enter the name of the Home Health Agency providing services |
| **PCP:** | Enter the PCP for the health plan member, if known. Leave blank if unknown. |
| **Diagnosis(es):** | Enter the description of the Member's diagnosis(es) that relate to the services being requested. |
| **ICD-10 Code(s):** | **(Required field ≥ 10-01-2015)** Enter the ICD-10 codes for the diagnoses that relate to the requested services. Diagnosis must be coded to the highest level of specificity. |
| **Certification Period*:** From __ to __ | Enter the time period needed to complete requested services |
| **Requested Services:** | Mark each level of care that is being requested, the quantity, and the date range it will take to complete the treatment |

| | |
|---|---|
| **Plan of Treatment:** | Describe services and other issues that need to be addressed during therapy sessions (time, duration, frequency, etc.) |
| **Phone #:** | Enter the phone of the requesting provider |
| **Signature of Requesting Provider:** | The person filling out the request must sign the form. |
| **Date:** | Enter the date the request is signed. |

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# Home Health Routing Slip

Member Name: _____ Authorization No. _____

Instructions:

1. Date and place your initials beside the item(s) being sent to Advanced Health along with a copy of this routing slip.
2. Fax forms to (541) 269-7147
3. Place copies in patient's chart

A. Initial 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of signed referral/order form
_____ 2. Copy of Plan's authorization form
_____ 3. Signed PPOT (CMS 485)
_____ 4. MD order (fax or order slip) for other discipline(s) and

Signed evaluation of ordered discipline _____ 5. Signed PPOT Addendum (CMS 487)
_____ 6. Opening evaluation notes

B. Recertification for subsequent 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of signed PPOT (CMS 485)
_____ 2. Copy of Plan's authorization form
_____ 3. Copy of order for other discipline(s) and signed

evaluation of ordered discipline. _____ 4. Copy of signed PPOT Addendum (CMS 487)

C. Resume – Is in 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of signed referral/order form
_____ 2. Copy of signed Resume orders

D. Significant change in condition – Is in 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of orders
_____ 2. Copy of signed evaluation of ordered discipline, if applicable
_____ 3. Copy of signed MD orders