

PHONE: 844-806-8217 Opt 3 FAX: 844-873-3163

## Home Health Prior Authorization Request Form \*\*\*Form must be filled out completely and clinical information attached\*\*\*

Person to Contact for th		Phone:			
Patient's Name:	[	OOB: /	/	Member ID:	
Requesting Provider In	formation:		Home H	ealth Agency Informa	tion:
Provider Name:			Home Health Agency Name:		
NPI:			NPI:		
Tax ID:			Tax ID:		
Address:			Address:		
Fax:			Fax:		
Phone:			Phone:		
Initial Start of Care Date:					
Certification Period Start:			End:		
Diagnosis(es):					
Service	CPT/HCPC Code	Number of Visits		From Date of Service for this request	To Date of Service f
Skilled Nursing Services					
Physical Therapy					
Occupational Therapy					
Speech Therapy					
MSW					
ННА					

This request will be processed per the standard organization determination timeframes. If this request needs to be treated as "expedited", please note clinical justification why applying the standard timeframe for a determination could seriously **jeopardize the member's life, health or ability to regain maximum function:** 

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions. Please refer to <a href="https://www.htanc.com">www.htanc.com</a> for specific codes requiring a prior authorization.



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## Physician orders are required for all INITIAL SOC requests. 485 and evidence of a face to face are required for all

An **SN** summary documenting the current clinical status with skilled need is required for **all SN** recert requests.

Please do not send the Oasis.

Examples of acceptable SN summary documentation:

- Change in condition describe what changes in patient's condition have occurred
- Unstable condition describe unstable condition and attach supporting documentation; examples include vital signs log, PT/INR log, blood sugar log, other abnormal labs that require SN intervention
- New and changed medications within 14 days describe what medications have changed or been added
- Wound clinical with photo; new photo required every 30 days to show progression
- Submit therapy evaluations and notes for all therapy services being requested.

Describe circumstances that require skilled services:					