Triad HealthCare Network Utilization Management

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PHONE: 844-873-2905 FAX: 844-873-3163

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

- ❑ **Evaluation** ❑ **Initial** ❑ **Recertification**
- ❑ **Additional Visits to Auth #**_____

Person to Contact for this request:	**Phone:**

Patient's Name:	**DOB:** / /	**Member ID**:

Requesting Provider Information:	**Home Health Agency Information:**
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 for this request
Skilled Nursing Services				
Physical Therapy				
Occupational Therapy				
Speech Therapy				
MSW				
HHA				

*****A new request for home health services must be submitted after every inpatient stay. Visits authorized prior to the hospitalization will not be valid for visits provided after the hospital stay. If the stay is observation, the existing authorized visits may be used.**

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 www.healthteamadvantage.com 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 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 haveoccurred
- 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: