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Home Health Prior Authorization Request Form

Form must filled out completely and clinical information attached

- Evaluation Initial Recertification
- Additional Visits to Auth # _____

Select this box if the member is new to HTA and these services were previously authorized by another health plan.

Person to Contact for this request:	Phone:
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Patient's Name:	DOB: / /	Member ID:
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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 <u>observation</u>, 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.htanc.com for specific codes requiring a prior authorization.

