Home Health Precertification Request Form

Date of Request: _____ **Requested Service(s):** ☐ RN ☐ MSW ☐ CNA ☐ PT ☐ OT ☐ ST	**PHP Utilization Management** **Phone 720.612.6600 l Fax 303.605.1545**

Member Info:

Last Name: _____ Insurance ID #: _____

First Name: _____ DOB: _____

Requesting Home Care Provider Info:

Home Care Agency Name: _____ Phone: _____

Office Contact: _____ Fax: _____

Physician Following Plan of Care:

Provider Name: _____ Phone: _____

Office Contact: _____

Home Health Care Authorization Request & Supporting Documentation Requirements:

☐ **Initial Review Period AFTER Start of Care (SOC) Visit:**
1. Attestation of **home bound status**
2. Start of Care Outcome and Assessment Information Set (**OASIS**)
3. Signed **Plan of Care** by following Physician or CMS-485 form – demonstrating plan for review by following physician
4. For Therapy – **Initial therapy evaluation** for each discipline requested is required at time of request

☐ **Continuation of Care (COC)- need for additional visits or services during current certification period:**
1. Current auth period **OASIS**
2. Clinical Notes – **Last 2 visit notes** per discipline involved **or** evaluation notes for any added services
3. Signed home health **Orders** from the physician overseeing the POC are required for any added services

☐ **Resumption of Care (ROC)- resumption of current home health needs after discharge from inpatient facility:**
1. Resumption of Care **OASIS** – **ROC**
2. **Discharge Summary** which includes reason for home health, inpatient admission and discharge dates
3. Signed home health **Orders** for resumption of home health services from the physician overseeing the POC (***Inpatient Attending orders are not acceptable.)***

☐ **Recertification- need for continuation of home care for an additional 60-day period:**
1. Updated attestation of **home bound status**
2. Recertification **OASIS** – **Recert**
3. Updated **Plan of Care** signed by following Physician or CMS-485 form – demonstrating plan for review by following physician
4. Updated Clinical Notes – **Last 2 visit notes** per discipline requested is required at time of request

☐ **ADDITIONAL CLINICAL ONLY for Authorization Request # _____**

Electronic signature or verbal order acceptable for signatures when physician name is clearly identified & included in the requested documentation

ICD-10 / Diagnosis Code	**1.**	**2.**	**3.**	**4.**
CPT Code including # of Visits per Code	**1.**	**2.**	**3.**	**4.**

Comments: _____

_____

****IMPORTANT****

To ensure a timely determination on your request, please include all the identified supporting documents with the request to PHP PA Department at 303.605.1545 (fax). This will help facilitate processing and eliminate need for unnecessary phone calls.

Authorization is not a guarantee of payment. Coverage will be determined based on eligibility and availability of remaining benefits at the time of service.