**UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM**

**NOTE: THIS FORM IS NOT TO BE USED FOR PCA SERVICES.**

Fax form and relevant clinical documentation to **(651)662-1004**

Or mail to: Utilization Management, P.O. Box 64265, St. Paul, MN 55164

**PLEASE NOTE: This form is NOT to be used for DHS FFS Home Health Services. It is to be used ONLY for Home Health Services covered by a health plan or a county-based purchasing plan.**

**In addition, this form is NOT to be used for PCA services. It is to be used ONLY for Home Health Services.**

Date:______________________ Start of Care Date:_____________

## Initial Authorization: Y/N Continued Authorization: Y/N

**Patient Information**

Name:_____________________________________________ Member Ins. ID:____________________________________

**Permanent Home**

Address:__________________________________________________________________________________________

City, State, Zip:_____________________________________________________________________________________

**Servicing address** (if patient is at a different address): _________________________________________________________

City, State, Zip:_______________________________________

Primary Phone:_____________________________________ Secondary Phone: _____________________________________

Group # _____________________________________________________

DOB:________________________________________________________

**Primary Diagnosis for Home Care Services and ICD-10 Codes**:___________________________________________________
**Other/Comorbid Diagnosis and ICD-10 Codes:**______________________________________________________________
**Homebound:** Y/N
**Location of Service:** Member Home ___ Assisted Living ____ Group Home ____ Foster Care ____ Customized Living ____
Other: _______________________________________________________________________________________________

**Home Care Agency Information**
Agency Name: _______________________________ NPI: ____________________Tax ID#: ____________________________
Address: _____________________________________________City, State, Zip ________________________________________
Contact Name: __________________________________________
Contact Phone:_____________________ Contact Fax:____________________________

**UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM**

**NOTE: THIS FORM IS NOT TO BE USED FOR PCA SERVICES.**

**MD/Ordering Provider Information**

Name: ______________________________________ NPI: _________________________ Clinic: _____________________

Clinic Address:____________________________________________ City, State, Zip________________________________

Clinic/MD Contact Phone Number: _____________________________ Fax number: _______________________________

Date of last appointment: ___________________________ Next visit date (If known):______________________________

**Service Request Information:**

| Type of Service | Procedure Code | Number of Visits Requested | Frequency | Start Date (this request) | End Date (this request) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Clinical Information/Summary/Comments:** [NOTE: Please attach the current CMS 485/Home care plan of care and clinical notes to support authorization request along with request.]

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Recent Hospitalization/Surgery: _________________________________________ D/C Date: ________________________