Universal Health Plan/Home Health Agency Prior Authorization Request Form

BlueCross BlueShield Minnesota

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 # _____ Date of birth:_____

Primary Diagnosis for Home Care Services and ICD-10 Codes:_____

Other/Comorbid Diagnosis and ICD-10 Codes:_____

Homebound: Yes ☐ No ☐

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:_____

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)**	**(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: _____