Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147
TTY: 711 or 800-735-1232

Home Health Authorization Request

• Fax Completed Form <u>and chart notes</u> to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Instructions to Complete Home Health Authorization Request:

- Requesting Provider is responsible to submitting all information in the top area of the form.
- Authorization requests must be accompanied with a signed Plan of Treatment/Evaluation. (Note: a current signed Prescribing Physician's prescription must be on file at the Home Health Agency's office for review upon request by Health Plan.)
- Follow-up requests for continuation of existing services must be made prior to expiration of current certification period.
- Recertification is required every 60 days from the initiation of treatment.
- Fax completed form, signed Plan of Care, and any other pertinent documentation to Health Plan's Medical Management Department at (541) 269-7147.
- If you have questions regarding this form or other related questions, please contact Health Plan's Medical Management Department at (541) 269-7400.

Member Name: ______________________________ Medicaid ID #: _______________ DOB: _____/_____/_____

Home Health Provider: ____________________________ PCP: ________________________________

Home Health Provider NPI#: ____________________________

ICD-10 Code(s):______________________________ Diagnosis(es):______________________________

*Required

Certification Period *: From _____/_____/_____ to _____/_____/_____

Level of Care	# of Visits	Date Range
☐ Physical Therapy Visit (421)		_____/_____/_____ to _____/_____/_____
☐ Occupational Therapy Visit (431)		_____/_____/_____ to _____/_____/_____
☐ Home Health Aide Visit (571)		_____/_____/_____ to _____/_____/_____
☐ Skilled Nursing Visit (551)		_____/_____/_____ to _____/_____/_____
☐ Speech Language Pathology Visit (441)		_____/_____/_____ to _____/_____/_____

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Comments:

Person Completing Form: ____

Contact Person:______________________________

Phone:____________________ Fax:____________________

Date: ____/____/____

<u>Disclaimer</u>: Prior Authorization does not guarantee payment. Criteria is based on member eligibility on date of service, contract terms, and compliance with OAR rules, regulations and policies of CMS and Advanced Health.
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Home Health Routing Slip

Member Name: _____ Authorization No. _____

Instructions:

1. Date and place your initials beside the item(s) being sent to Advanced Health along with a copy of this routing slip.
2. Fax forms to (541) 269-7147
3. Place copies in patient's chart

A. Initial 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of signed referral/order form
_____ 2. Copy of Plan's authorization form
_____ 3. Signed PPOT (CMS 485)
_____ 4. MD order (fax or order slip) for other discipline(s) and

Signed evaluation of ordered discipline _____ 5. Signed PPOT Addendum (CMS 487)
_____ 6. Opening evaluation notes

B. Recertification for subsequent 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of signed PPOT (CMS 485)
_____ 2. Copy of Plan's authorization form
_____ 3. Copy of order for other discipline(s) and signed

evaluation of ordered discipline. _____ 4. Copy of signed PPOT Addendum (CMS 487)

C. Resume – Is in 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of signed referral/order form
_____ 2. Copy of signed Resume orders

D. Significant change in condition – Is in 60 day episode of care:
Dates: _____/_____/_____ to _____/_____/_____

_____ 1. Copy of orders
_____ 2. Copy of signed evaluation of ordered discipline, if applicable
_____ 3. Copy of signed MD orders