Health Partners Plans

# Home Care Authorization Request Form

| General Information | | |
|---|---|---|
| **Today's Date:** | **Initial Start of Care Date:** | |
| **Member Name:** | **Member ID #:** | **Member DOB:** _____ / _____ / _____ |

| Homecare Provider | | |
|---|---|---|
| **Provider Name:**<br><br>**Contact Name:** | **Address (City, State, Zip)** | **Phone #**<br><br>**Fax #** |
| **PROMISe ID:** _____ | **NPI:** _____ | |

| Ordering Physician |
|---|
| **Ordering Physician Name:** |
| **PROMISe ID:** _____ **NPI:** _____ |
| **Principal Diagnosis (ICD 10/ Description):** |
| **Clinical Info:** |

| Service Requested | Date Range of Visits<br>e.g., 1/1/2017 – 2/15/2017 | Total Number of Visits |
|---|---|---|
| ☐ R.N. | | |
| ☐ P.T. | | |
| ☐ O.T. | | |
| ☐ S.T | | |
| ☐ MSW | | |
| ☐ HHA | | |

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

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**R.N.**

☐ Assess/Evaluation ☐ Active Co-morbidity ☐ Adjustment in TX/Medication Regime

☐ Cognitive Deficit ☐ Knowledge Deficit ☐ Physical Deficit

☐ New Onset of Symptoms ☐ Wound Care ☐ Wound Present

*Measurements:* Length: _____ Width: _____ Depth: _____

*Goals:* _____

**P.T.**

☐ Assess/Evaluation ☐ Therapeutic Exercises ☐ ADL/Mobility/Transfer Training

☐ HEP ☐ Home Safety ☐ Strength/ROM

☐ Other: _____

*Goals:* _____

**O.T.**

☐ Assess/Evaluation ☐ Teaching ☐ ADL/Mobility/Transfer Training

☐ HEP ☐ Other: _____

*Goals:* _____

**S.T.**

☐ Assess/Evaluation ☐ Speech Retraining ☐ Cognitive Deficit

☐ Aspiration Precaution ☐ Feeding Training ☐ Verbal Motor Training

☐ Cognitive Sentence Recognition ☐ Cognitive Word Finding

☐ Other: _____

*Goals:* _____

**MSW**

☐ Assess/Evaluation ☐ Assistance with Referrals ☐ Long Term/Financial Planning

☐ Family Caregiver Instructions ☐ Other: _____

*Goals:* _____

**HHA**

☐ Assist with Personal Care ☐ Promote Independence ☐ Promote Dignity and Hygiene

☐ Other: _____

*Goals:* _____

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