



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Home Health Services/Home Hospice Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.

Provider Information

Provider Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Enrollee Information

Patient Name: _____
 ID Number: _____
 Patient DOB: _____
 Address: _____
 Phone: _____

Ordering Physician Information

Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Referred to Agency from: Hospital SNF Rehab Physician Other

If Physician or Other please specify: _____

Treatment Information

Diagnosis (ICD-9) Code: _____
 Pertinent Medical History (submit history, physical and include previous treatments and dates): _____

Service Requested: Home Health Services Home Hospice

Current Medical & Functional Status Summary: (pertaining to Home Services)

Is the patient homebound? YES NO
 Where does the patient reside? Home SNF Other
 Does the patient have a Primary Care Giver? YES NO

If yes, please specify: _____

Home Status/Social Support/Potential Discharge Barriers: _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Treatment Plan:* (include wound measurements) _____

Type of Service Requested:

**Preferred provider available for DME and HI services*

	# visits	Start Date	End Date
RN			
HHA			
PT			
OT			
ST			
MSW			
Hospice			

Skilled Nursing Services Requested:

Central line dressing changes

Dressing changes with prescribed medication

IV Fusions

Control pain and other symptoms

Educate care giver with regards to treatment regimen

Skilled observation and monitoring when necessary, specify _____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____