PHCN

FOR FASTER SERVICE, PLEASE COMPLETE AT:
https://prohcn.com/referral-auth-upload/

OR FAX TO: (877) 225-9710

HOME HEALTH CARE REQUEST RE-AUTHORIZATION FORM

Questions? Call (888) 705-5274

Date of Request:	**Current Cert Period Dates:**	**Agency Name:** _____**NPI:**_____ **Contact Name:**_____ **Phone:** _____ **Fax:** _____ ***Return Approved Authorization to (Email or Fax):***
Patient Name: _____ **DOB:** _____ **Patient State of Residence:** _____		**Clinician Name:** _____ **Phone:** _____ **Fax:** _____ **Email:** _____

Additional Visits:

Add visits for a discipline already in the home:

SN Visits: _____ Dates : _____ PT Visits: _____ Dates: _____

OT Visits: _____ Dates: _____ ST Visits: _____ Dates: _____

MSW Visits: _____ Dates: _____ HHA Visits: _____ Dates: _____

Additional Discipline:

Add check for discipline(s) that are NOT already in the home:

SN: ☐ PT: ☐ OT: ☐ ST: ☐ MSW: ☐ HHA: ☐

Extend Current Period:

Extend a service period for which not all visits could be completed timely:

Discipline: _____ Reference Number: _____

Current End Date: _____ Requested End Date: _____

Summary:

Agency Name: _____**NPI:**_____

Date of Request:

Patient Name: _____

DOB: _____

PHCN RESPONSE TO REQUEST FOR ONGOING REVIEW:

Discipline	Number of Visits	Reference Number	Review Period
SN:	_____	_____	_____
PT:	_____	_____	_____
OT:	_____	_____	_____
ST:	_____	_____	_____
MSW:	_____	_____	_____
HHA:	_____	_____	_____

Comments

RA notification to agency confirms receipt of determination with approved visits. Should you disagree with approval please notify PHCN UM Department at (602)-395-5100. Should a material change in member status occur, submit an additional request with pertinent clinical documentation.

Reviewed By: _____ Date: _____