HOME HEALTH CARE NEW REFERRAL/INITIAL AUTHORIZATION FORM

PLEASE SEND THE COMPLETED FORM ALONG WITH THE REQUIRED INFORMATION TO: FAX 877-612-7066
or UPLOAD TO: https://prohcn.com/upload/phcn-referral-upload/

Date of Request:

SOC Date:

Standard Request: ☐

Retrospective Review: ☐

Urgent Request: ☐ **Note: Expedited organization determinations (urgent/stat requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS Part C&D regulation: 40.8)**

Member Name: _____
DOB: _____
Member Address: _____

_____

Member Phone number: _____
Emergency Contact Name, Relationship & Number: _____

Member Preferred Language: _____

Referral Source:

☐ Hospital ☐ SNF/Rehab ☐ Other

☐ MD Office ☐ HH Agency

Name: _____

NPI: _____

Contact: _____

Phone: _____ Fax: _____

Health Plan Name: _____
Member ID (Required): _____
Medicare HICN/Medicaid ID#: _____

Accepting Agency Name / Branch: _____

Agency NPI: _____

Agency Contact Name: _____

Agency Phone: _____

Agency Fax: _____

Send Approved Auth to: (Email of Fax): _____

COVID-19 Test Results: ☐ NEG ☐ POS ☐ UNKNOWN

DATE: _____

Date of D/C:

Primary DX (include ICD-10 code):

_____

Past Medical Hx/Secondary DX:

_____

Ordering Prescriber Name: _____
Ordering Prescriber NPI: _____
Address: _____

_____

Phone: _____

Fax: _____

Patient's PCP Name and Number:

_____

_____

Care Type Required:

☐ Lovenox Injections
☐ Feeding Tube
☐ LVAD
☐ Trach

PICC line care*

Behavioral Health / Psychiatric*

Home Infusion therapy*

***PHCN is not contracted, these care types must be coordinated through the Health Plan**

Clinical Categories: *CHOOSE ONE*

☐ General/Other
☐ THR/TKR/ORIF (No Rehab)
☐ THR/TKR/ORIF (With Rehab)
☐ Wound Care/Wound Vac
☐ Foley Catheter
☐ CABG/Heart Surgery
☐ CVA (Within past 60 days)
☐ Diabetes (NIDD)
☐ Ostomy (new placement within 60 days)
☐ Musculoskelatal Pain (i.e, back pain)
☐ Neuromuscular
☐ Sepsis/ UTI
☐ Pleurex Drain
☐ Aspiration Pneumonia

Which Skilled Disciplines are Ordered for Start of Care? *CHOOSE ALL THAT APPLY*

☐ Skilled Nursing
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Home Health Aide (must be paired with SN, PT, OT or ST)
☐ Medical Social Worker (must be paired with SN, PT, OT or ST)
☐ Nurse to Open Required

Additional order details (e.g. RLE wound care, teach wet to dry dressing TIW,etc.): _____

_____

Please submit the following as attachments:

☐ MD, DO, DPM, NP or PA Home Healthcare signed/verbal order **(required)**

☐ Supporting Clinical Documentation **(required)**

Please provide the following, as applicable:

☐ H&P
☐ Inpatient Discharge Summary
☐ Notes from Hospital or SNF (including any therapy notes)
☐ MD Office Notes
☐ Wound Care Notes with Measurements