



HOME HEALTH CARE NEW REFERRAL/PRIOR 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:	Standard Request: <input type="checkbox"/>	Urgent Request: <input type="checkbox"/> 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)
SOC Date:	Retrospective Review: <input type="checkbox"/>	
Member Name: _____ DOB: _____ Member Address: _____ _____ Member Phone number: _____ Emergency Contact Name, Relationship & Number: _____ Member Preferred Language: _____		Referral Source: <input type="checkbox"/> Hospital <input type="checkbox"/> SNF/Rehab <input type="checkbox"/> Other <input type="checkbox"/> MD Office <input type="checkbox"/> 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 or Fax): _____
COVID-19 Test Results: <input type="checkbox"/> NEG <input type="checkbox"/> POS <input type="checkbox"/> UNKNOWN DATE: _____		Ordering Prescriber Name: _____ Ordering Prescriber NPI: _____ Address: _____ _____ Phone: _____ Fax: _____ Patient's PCP Name and Number: _____
Date of D/C: Primary DX (include ICD-10 code): _____ Past Medical Hx/Secondary DX: _____		
Care Type Required: <input type="checkbox"/> Lovenox Injections <input type="checkbox"/> Feeding Tube <input type="checkbox"/> LVAD <input type="checkbox"/> 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: <u>CHOOSE ONE</u> <input type="checkbox"/> General/Other <input type="checkbox"/> THR/TKR/ORIF (No Rehab) <input type="checkbox"/> THR/TKR/ORIF (With Rehab) <input type="checkbox"/> Wound Care/Wound Vac <input type="checkbox"/> Foley Catheter <input type="checkbox"/> CABG/Heart Surgery <input type="checkbox"/> CVA (Within past 60 days) <input type="checkbox"/> Diabetes (NIDD) <input type="checkbox"/> Ostomy (new placement within 60 days) <input type="checkbox"/> Musculoskeletal Pain (i.e, back pain) <input type="checkbox"/> Neuromuscular <input type="checkbox"/> Sepsis/ UTI <input type="checkbox"/> Pleurex Drain <input type="checkbox"/> Aspiration Pneumonia	Which Skilled Disciplines are Ordered for Start of Care? <u>CHOOSE ALL THAT APPLY</u> <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Home Health Aide (must be paired with SN, PT, OT or ST) <input type="checkbox"/> Medical Social Worker (must be paired with SN, PT, OT or ST) <input type="checkbox"/> 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: <input type="checkbox"/> MD, DO, DPM, NP or PA Home Healthcare signed/verbal order (required) <input type="checkbox"/> Supporting Clinical Documentation (required) Please provide the following, as applicable: <input type="checkbox"/> H&P <input type="checkbox"/> Inpatient Discharge Summary <input type="checkbox"/> Notes from Hospital or SNF (including any therapy notes) <input type="checkbox"/> MD Office Notes <input type="checkbox"/> Wound Care Notes with Measurements