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:

SOC Date:

Standard Request: ☐

Retrospective Review: ☐

Referral Source:

☐ Hospital ☐ SNF/Rehab ☐ Other MD Office

Name: ______________________

NPI: ______________________

Contact: ______________________

Phone: ____________ Fax: ____________

Member Name: ______________________

DOB: ______________

Member Address: ______________________

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Member Phone number: ______________________

Emergency Contact Name, Relationship & Number: ______________________

Member Preferred Language: ______________________

Accepting Agency Name / Branch

Agency NPI: ______________________

Agency Contact Name: ______________________

Agency Phone: ______________________

Agency Fax: ______________________

Send Approved Auth to: (Email or Fax): ______________________

Health Plan Name: ______________________

Member ID (Required): ______________________

Medicare HICN/Medicaid ID#: ______________________

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

DATE: ______________________

Ordering Prescriber Name: ______________________

Ordering Prescriber NPI: ______________________

Address: ______________________

____

Phone: ______________________

Fax: ______________________

Patient's PCP Name and Number:

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____

Date of D/C:

Primary DX (include ICD-10 code):

____

Past Medical Hx/Secondary DX:

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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
- ☐ 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.): ______________________

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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