Medicare Advantage Prior Authorization
Home health care form

HealthSpring℠

This form is for Arizona only. Providers must get prior authorization for home health care. Prior authorization isn't guarantee of payment. Payment is subject to coverage, patient eligibility and contractual limitations. **Please use the appropriate form for durable medical equipment and generic prior authorization requests.**

Date / /	**Please check request type**	
☐ Concurrent review request Start of care date ____/____/_____ OR Last covered day ____/____/_____ What is the request? ☐ Initial request ☐ Extension ☐ Recertification	☐ Expedited request – may take up to 72 hours **I certify that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.** _____ Provider signature required	
Member name Member phone	Requesting provider	National Provider Identifier
Member ID	HHC Agency	HHC NPI
Member date of birth / /	Contact name	
Initial care start date / /	Contact phone	Contact fax

Was member discharged from hospital in past 30 days?

☐ No

☐ Yes, member was discharged on ____/____/_____ Facility name _____

Attending physician _____ Attending physician phone _____

Is member homebound?

☐ No

☐ Yes. Please provide supporting documentation.

ICD-10 code _____ ICD-10 code _____ ICD-10 code _____

ICD-10 code _____ ICD-10 code _____ ICD-10 code _____

ICD-10 code _____ ICD-10 code _____ ICD-10 code _____

Able and willing teachable caregiver? ☐ No ☐ Yes

If no, explain: _____

_____

_____

Please submit the following clinical documentation:

- Start of care recertification or resumption Outcome and Assessment Information Set documents, as applicable, and therapy evaluations
- CMS-485 form or orders
- Wound notes
- Supporting clinical documentation, such as clinical visit notes from last 14 days, physician progress notes, history and physical exam, or hospital discharge.
- Include notice of Medicare noncoverage or discharge summary for member discharged from home health in last 60 days
- Discharge or transfer OASIS and notice of Medicare noncoverage

Provide total number of completed visits

	Nurse	Physical therapy	Occupational therapy	Speech therapy	Medical social worker	Home health aid
Visits completed						
Dates of service						

Home health services requested	Services providing
☐ Skilled nursing Plan of care frequency:	☐ Wound care ☐ Foley or PEG care ☐ Access care ☐ Skilled teaching ☐ Injections or infusion ☐ Other
☐ Physical therapy ☐ Occupational therapy ☐ Speech-language therapy All therapy requests should include current level of function and goals or progress toward goals. Plan of care frequency:	☐ Evaluation and treatment ☐ Maintenance therapy
☐ Home health aide or medical social worker Plan of care frequency:	Initial assessment of qualifying service must be attached.

Please fax this form and supporting clinical information to:

Department/Delegate	Phone	Fax	Hours
Tango	602-395-5100	877-612-7066	Monday - Friday, 9 a.m. to 7 p.m. (CT) Saturday and Sunday, 9:30 a.m. to 6 p.m. (CT)