

Home Health Care Prior Authorization Request Form

Home Health PA Request Form
October 2018

FAX ALL DOCUMENTATION TO (801)323-1562

**Asterisk indicates required field*

<p>*Date of Submission: _____ *Number of Pages Submitted: _____</p> <p>*CERTIFICATION PERIOD DATES (From 485 plan of care): _____ - _____</p> <p>* PROVIDER TYPE (choose one):</p> <p><input type="checkbox"/> 54- Personal Care Agency</p> <p><input type="checkbox"/> 58-Medicare Certified Home Health Agency</p>	<p>*6. HAS ELIGIBILITY BEEN VERIFIED? <input type="checkbox"/> Yes <input type="checkbox"/> No https://medicaid.utah.gov/eligibility</p> <p>*7. IS THE MEMBER ENROLLED IN A MANAGED CARE ORGANIZATION? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, contact the member's MCO for prior authorization)</p> <p>*8. DOES THE SERVICE CODE BEING REQUESTED REQUIRE PRIOR AUTHORIZATION? <input type="checkbox"/> Yes <input type="checkbox"/> No http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php</p> <p>*9. CHANGE TO AN EXISTING PA: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, PA#: _____ (Note: Must complete section 14-17 below)</p>
<p>*1. MEMBER NAME: _____</p> <p>*2. MEDICAID ID#: _____ *3. GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>*4. DATE OF BIRTH: _____ *5. AGE: _____</p>	

PLEASE USE THIS SECTION FOR INITIAL REQUEST OF SERVICES

10. DESCRIPTION OF REQUESTED SERVICE <small>(e.g. Skilled Nurse, PT, OT, Home Health Aide)</small>	11. CPT/HCPCS/MODIFIER	12. UNITS/VISITS	13. DATE(S) OF SERVICE
1)			
2)			
3)			
4)			

PLEASE USE THIS SECTION FOR MODIFICATIONS TO AN EXISTING AUTHORIZATION (e.g., change to dates or units, additional services needed)

14. DESCRIPTION OF REQUESTED SERVICE <small>(e.g. Skilled Nurse, PT, OT, Home Health Aide)</small>	15. CPT/HCPCS/MODIFIER	16. CHANGE IN UNITS/VISITS	17. DATE(S) OF SERVICE TO BE MODIFIED
1)			
2)			
3)			
4)			

18. SUMMARY OF HISTORY/EXPLANATION OF CHANGES TO PREVIOUS AUTHORIZATION: Applicable documentation must be supplied in sufficient detail to justify the necessity of the service that is being requested. Please see the Utah Medicaid Home Health Services manual for criteria of requested service. If this is a request to change/update the original PA, please document clearly what changes are requested or the request may be returned due to lack of information):

NOTE: Supporting documentation must be submitted to substantiate any information provided in this field.

***19. HOME HEALTH AGENCY INFORMATION**

NAME: _____ ADDRESS: _____

NPI#: _____

PHONE: (____) _____ FAX: (____) _____

OFFICE CONTACT NAME: _____

***20. PRESCRIBING PROVIDER INFORMATION**

NAME: _____ PHONE: (____) _____

PRIOR AUTHORIZATION DOES NOT GUARANTEE REIMBURSEMENT. ALL OTHER MEDICAID REQUIREMENTS MUST BE MET IN ORDER FOR A PROVIDER TO RECEIVE REIMBURSEMENT, INCLUDING VERIFYING CODE COVERAGE FOR EACH PROVIDER TYPE. UTAH MEDICAID PROVIDERS ARE EXPECTED TO CHECK ELIGIBILITY AT EACH VISIT, INCLUDING HEALTH PLAN PARTICIPATION AND RESTRICTED MEMBER STATUS.

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INSTRUCTIONS FOR HOME HEALTH CARE PRIOR AUTHORIZATION REQUEST FORM

ALL BOLDED INFORMATION BELOW MUST BE COMPLETED LEGIBLY AND CORRECT OR THE REQUEST WILL BE RETURNED WITHOUT BEING PROCESSED

Date of Submission**Number of Pages Submitted****Certification Period Dates** (From 485 Plan of Care)**Provider Type** (54- Personal Care Agency or 58-Medicare Certified Home Health Agency)

1. **Member Name**
2. **Medicaid ID #** (10 digit Utah Medicaid Member Number)
3. **Gender**
4. **Date of Birth**
5. **Age**
6. **Has eligibility been verified?** (Provider must check eligibility with each visit)
7. **Is the member enrolled in a Managed Care Plan?** (Provider must verify with each visit)
8. **Does the service code being requested require prior authorization?** (Verify using the coverage and reimbursement lookup tool)
9. **Change to a current prior authorization?** (If requesting a change to a previously issued authorization, complete fields 14-17)

Initial Request for Services (Only use this section if an authorization for services has not been issued for this certification period. If services have already been authorized for this certification period, use the modification section below instead.)

10. Description of requested service (e.g. skilled nurse, PT, OT, Home Health Aide)
11. CPT/HCPCS/Modifier
12. Units/Visits
13. Date(s) of Service

Modifications to an existing prior authorization (Use this section to request a change to a previously issued authorization. List all services that need to be added or reduced, or to request a change in units or date(s) of service. Please calculate only the units that need to be added or reduced based on the number of units previously authorized. For example: if 10 visits were previously authorized and 5 additional visits are needed, only enter the 5 additional units needed, opposed to the 15 total units for the certification period.)

14. Description of requested service (e.g. skilled nurse, PT, OT, Home Health Aide)
15. CPT/HCPCS/Modifier
16. Units/Visits
17. Date(s) of Service

18. Summary of History/Explanation of changes to a previous authorization (Use this section to provide a summary of the patient's history and/or to explain any changes that are being requested on a previously issued authorization.)

19. Home Health Agency Information**20. Prescribing Provider Information**

IF FAX IS NOT AVAILABLE, MAIL THE ORIGINAL COMPLETED FORM AND ANY ATTACHMENTS TO:

MEDICAID PRIOR AUTHORIZATION BOX 14311
SALT LAKE CITY UT 84114-3111
Attention: Prior Authorization

Medicaid Information:

In the Salt Lake City area(801)538-6155

Toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado(800)662-9651

From all other areas(801)538-6155