Prior Authorization Form

Please Fax To (952)853-8712 For Questions Call (888) 467-0774

Home Health Care Prior Authorization Form

Member and Provider information	
Member Name:	MD Name (First & Last):
Member ID #:	Clinic & Address:
DOB:	Phone #:
Primary Dx & Code:_____	Fax #:
	Additional Dx Codes: _____

Home Care Agency (HHC): _____ Tax ID #: _____

Phone #: _____ HHC Agency Fax #: _____

HHC Agency Contact Name: _____ Medicare Certified: ☐ Y ☐ N

Contracted Provider: ☐ Y ☐ N

Prior Authorization Initial Request: ☐ Y ☐ N Continued Care Re-authorization: ☐ Y ☐ N

Existing Auth Start Date: _____ Auth End Date: _____

Is Member homebound: ☐ Y ☐ N Reason Member Homebound: _____

_____

Member is Being Discharged From Hospital/Facility? ☐ Y ☐ N If Yes, Planned Facility DC Date? _____

Date of Next MD visit: _____

FAX Current Clinical Information & Progress Notes to: **Fax # 952-853-8712**

CoOportunity Health has contracted with HealthPartners Administrators, Inc. to provide claims processing, medical management and certain other administrative services.

Auth Requested for/ Frequency and duration:	Number of visits requested	Start Date	Proposed End Date
Skilled Nursing			
Home Health Aide			
Physical Therapy			
Occupational Therapy			
Speech Therapy			

Wound Care information if applicable:

Location: _____

Length (in cm): _____ Width (in cm): _____ Depth (in cm): _____