HIGHMARK

HIGHMARK BLUE SHIELD
HOME HEALTH
PRECERTIFICATION WORKSHEET

Submission Instructions: Please print all information.

IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS.** Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.

Please fax completed form to the Medical Management and Policy Department: **888.567.5703**

Type of Request:		
PICK ONE:	**INITIAL REQUEST** ☐	**EXTENSION REQUEST** ☐
Demographic Information:		
Date:	Verification of Benefits: ☐ Yes ☐ No	
Patient Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Member UMI Number:	Group Number:	
Precertification Number:	Patient Phone Number:	
Patient Address:		
Subscriber Name:		
Admission Information:		
Agency Name:	Agency NPI # :	
Agency Phone #:	Agency Fax #:	
Agency Address:		
Physician Name:	Physician NPI #:	
Physician Phone #:	Physician Fax #:	
Physician Address:		
Date of Admission to Home Health:		
Prior Hospitalization: Facility	From:	To:
Homebound?	Yes ☐	No ☐
If yes, reason for homebound status:		
Medical Information:		
Primary Diagnosis:	Code:	
Secondary Diagnosis:	Code:	
Medical History:		

Member's Name:	**Member's UMI #:**

Current Medical Status/Treatment Plan (Include medications, diet, vital signs, weight, wounds and sizes, nursing assessment, etc.):

Estimated Length of Stay:	Next MD Appointment:

Living Arrangements:

Caregiver Availability:

Willing and Able Caregiver: ☐ Yes ☐ No Lives with patient: ☐ Yes ☐ No

Relationship:

Community Resources: ☐ Yes ☐ No If Yes, Explain/List:

Please check referrals for any additional services:

☐ Physical Therapy	☐ Speech Therapy	☐ Occupational Therapy
☐ Medical Social Worker	☐ Home Health Aide	☐ RN

Requested Visits and Date Ranges for Each Discipline:

RN:	PT:	OT:	ST:	AIDE:	MSW:
Dates:	Dates:	Dates:	Dates:	Dates:	Dates:

Discharge Date:	Signature of Home Health Agency Nurse:

If request for extension of services: Specific reasons for continued service, progress, or any other pertinent info related to extension of services:

Additional Comments:

Completed by:	Date:	
Title:	Phone #:	Fax #:

For Internal Use Only:

Decision: ☐ **Approved** ☐ **Denied**	Initial of Reviewer:	
Nurse Reviewer:	# Visits Approved:	Total # of Visits to Date:
Review Date:	Call Back Date:	