

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 <u>ONE</u> :	INITIAL REC		ENSION REQUEST			
Demographic Information: Date:		Verification of Benefi	its: 🗆 Yes 🗆 No			
Patient Name:		Date of Birth:	Sex: Male Female			
Member UMI Number:		Group Number:				
Precertification Number:		Patient Phone Numb	Patient Phone Number:			
Patient Address:		<u>'</u>				
Subscriber Name:						
Admission Information:						
Agency Name:		Agency NPI #:	Agency NPI #:			
Agency Phone #:		Agency Fax #:				
Agency Address:		1				
Physician Name:		Physician NPI #:	Physician NPI #:			
Physician Phone #:		Physician Fax #:	Physician Fax #:			
Physician Address:						
Date of Admission to Home Hea	lth:					
Prior Hospitalization: Facility	From:	To:				
Homebound?	Yes 🗌	No 🗌				
If yes, reason for homebound sta	atus:					
Medical Information:						
Primary Diagnosis:		Cod	de:			
Secondary Diagnosis:		Cod	de:			
Medical History:		1				

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 Tr									
☐ Medical Social Worker ☐ Home Hea			alth Aide	9	RN				
Requested Visits and Date Ranges for Each Discipline:									
RN:	PT:	OT:		ST:	AIDE:	MSW:			
Dates:	Dates:	Dates:		Dates:	Dates:	Dates:			
D: 1 D :		0:							
Discharge Date: Signature of Hom			Home H	ome 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	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:						
Tronon Balo.			Juli Davit Date.						