Member Name_____Phone #_____

Care Coordination Plan ID# _____

Prior Authorization Form
for
Home Health Care Services

If your agency completes an OASIS form, it may be submitted in place of the Prior Authorization Form.

If this is a new request, you may call the Care Coordination Plans' Medical Management Department to request initial nursing visits and therapy visits.

Agency name: _____

Contact name and number:_____

Agency fax number:_____

Dates of service: _____

Acute/Chronic Diagnosis: _____

Recent Hospitalization: _____

Diagnosis:_____

Admit date: _____ **Discharge date:** _____

Last physician appointment by ordering physician?_____

Last physical /occupational therapy assessment?_____

Services requested:

SN x _____visits

Supervision of the Home health aide only? Yes_____ No _____

OAC 5101:3-12-01 Home Health Services: Provision Requirements, Coverage and Service Specifications. F(1)(e) Nursing visits are not covered when the visit is solely for the supervision of the home health aide.

HOME HEALTH AIDE x_____hours and /_____days. Billing code:

Please provide current HOME HEALTH AIDE schedule (days and times service provided)

Physical therapy_____visits/wk x _____wk

Occupational therapy_____visits/wk x_____wk

Speech therapy_____ visits/wk x_____wk

Medical Social Worker_____visits

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Full Name of Ordering Physician: _____

Physician Phone Number: _____

Physician Fax Number:_____

CP Name: _____

Does this match the PCP listed on the member's Care Coordination Plan? Yes _____ **No**_____If a PCP assignment needs to be changed, please request that the member call their Care Coordination Plan at the end of your visit.

When was the last PCP visit? _____

When is the next PCP visit? _____

If a PCP appointment needs to be scheduled, please request that the member call their Care Coordination Plan at the end of your visit.

Please ask the following questions during your visit for case management outreach:

What is the best time of the day for a Care Coordination Plan case manager to contact the member?

Morning _____ Afternoon _____ Evening _____

When can a Care Coordination Plan case manager call you? (8 a.m. -7 p.m., Monday through Friday)

Follow up call: Date _____ Time _____

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CURRENT RESIDENCE:

- ☐ Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
- ☐ Family member's residence
- ☐ Boarding home or rented room
- ☐ Board and care or assisted living facility
- ☐ Other _____

SUPPORTIVE ASSISTANCE

Assisting Person(s) Other than Home Care Agency Staff*: (Mark all that apply)*

- ☐ Relatives, friends, or neighbors living outside the home
- ☐ Person residing in the home (EXCLUDING paid help)
- ☐ Paid help
- ☐ None of the above

How often does this person assist you?_____

What other support systems does the member have? _____

_____

Member Name_____Phone #_____

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☐ **The patient has a wound.**

If yes, describe wound: (size, location, treatment, how long has the wound been present)

_____

_____

☐ There is someone to assist member with wound care (after education).

☐ The patient has bowel or bladder incontinence.

☐ The patient requires ostomy care.

☐ There is a caregiver who can be taught ostomy care.

Please describe: _____

_____

Please describe any medical or treatment change since last certification period.

_____

_____

_____

Does the member have any durable medical equipment in the home?

Please describe:_____

_____

What barriers to utilizing outpatient services exist that may need to be addressed?

Please describe any medical or treatment change since last certification period.

_____

_____

_____

Member Name_____Phone #_____

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What community agencies is the member involved with?

Please list name of agency/case managers with phone numbers:

_____

_____

MEDICATION MANAGEMENT:

☐ Able to independently take oral or injection and proper dosage at correct times.

☐ Able to take oral /injection at correct times if prepared in advance by another person OR given reminders.

☐ Unable to take medications unless given by another person.

ACTIVITIES OF DAILY LIVING /INSTRUMENTAL ACTIVITIES OF DAILY LIVING; ***(please check appropriate response)***

Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). *45 minutes assistance per day is needed*

☐ Able to groom self unaided, with or without the use of assistive devices or adapted methods.

☐ Grooming utensils must be placed within reach before able to complete grooming.

☐ Someone must assist the patient to groom self.

☐ Patient depends entirely upon someone else for grooming needs.

Ability to dress upper body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps: *30 minutes assistance per day is needed*

☐ Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.

☐ Able to dress upper body without assistance if clothing is laid out or handed to the patient.

☐ Someone must help the patient put on upper body clothing.

☐ Patient depends entirely upon another person to dress the upper body.

Member Name_____Phone #_____

Care Coordination Plan ID# _____

Ability to dress lower body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

☐ Able to obtain, put on, and remove clothing and shoes without assistance.

☐ Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.

☐ Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.

☐ Patient depends entirely upon another person to dress lower body.

Bathing: Ability to wash entire body. Excludes grooming (washing face and hands only). *45 minutes is allowed per day when assistance is needed*

☐ Able to bathe self in shower or tub independently.

☐ With the use of devices, is able to bathe self in shower or tub independently.

☐ Able to bathe in shower or tub with the assistance of another person:

- for intermittent supervision or encouragement or reminders, OR
- to get in and out of the shower or tub, OR
- for washing difficult to reach areas.

☐ Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.

☐ Unable to use the shower or tub and is bathed in bed or bedside chair.

☐ Unable to effectively participate in bathing and is totally bathed by another person.

Toileting: Ability to get to and from the toilet or bedside commode. *30 minutes assistance per day is needed*

☐ Able to get to and from the toilet independently with or without a device.

☐ When reminded, assisted, or supervised by another person, able to get to and from the toilet.

☐ Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).

☐ Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.

☐ Is totally dependent in toileting.

Member Name_____Phone #_____

Care Coordination Plan ID# _____

Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast. *30 minutes assistance per day is needed*

- ☐ Able to independently transfer.
- ☐ Transfers with minimal human assistance or with use of an assistive device.
- ☐ Unable to transfer self but is able to bear weight and pivot during the transfer process.
- ☐ Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ☐ Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ Bedfast, unable to transfer and is unable to turn and position self in bed.

Ambulation/Locomotion: Ability to safely walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ Requires use of a device (i.e., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ Able to walk only with the supervision or assistance of another person at all times.
- ☐ Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ Chairfast, unable to ambulate and is unable to wheel self.
- ☐ Bedfast, unable to ambulate or be up in a chair.

Planning and Preparing Light Meals (i.e., cereal, sandwich) or reheat delivered meals:

- ☐ Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  - ○ Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- ☐ Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- ☐ Unable to prepare any light meals or reheat any delivered meals.

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Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

- ☐ Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
- ☐ Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
- ☐ Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.

Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

- ☐ Able to independently perform all housekeeping tasks; OR
  - Is physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission).
- ☐ Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
- ☐ Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
- ☐ Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
- ☐ Unable to effectively participate in any housekeeping tasks.

Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

- ☐ Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR is physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).
- ☐ Able to go shopping, but needs some assistance:
  - By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR
  - Unable to go shopping alone, but can go with someone to assist.
- ☐ Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
- ☐ Needs someone to do all shopping and errands

Summary information: please provide a summary regarding needs of this patient and /or 60-day summary information:

_____

_____

_____

_____

_____

_____

_____

Member Name_____Phone #_____

Care Coordination Plan ID# _____

☐ **EVALUATION REQUEST**

☐ **INITIAL REQUEST**

☐ **REAUTHORIZATION REQUEST (*for ongoing services)***

☐ **URGENT REQUEST (justification)**_____

- **NOTE: May call for urgent requests**

For initial request please complete this form.

For reauthorization requests please complete this form and include nursing/therapy notes if needed to demonstrate medical necessity.

Services authorized:_____

Dates of service:_____

RETURN FORM BY U.S. MAIL OR FAX:

Managed Care Plan- web	Fax	Phone
amerigroupcorp.com	866-495-3893	800-600-4441
www.bchpohio.com		
NE/SW Region:	866-704-3069	866-246-4359
EC Region:	866-535-4083	866-246-4359
NW Region:	866-535-4084	866-246-4359
www.caresource-ohio.com	888-752-0012	800-488-0134
www.molinahealthcare.com	866-449-6843	800-642-4168
www.unisonhealthplan.com	866-839-6454	800-366-7304
www.ohio.wellcare.com DME/PT/OT/ST	877-431-8859	800-951-7719
Outpatient Services	877-277-1820	800-951-7719
Inpatient Services	877-431-8860	800-951-7719
OB Notification	877-647-7475	800-951-7719
Pharmacy/Infusion Services	877-277-6892	800-951-7719
www.paramounthealthcare.com	866-214-2024	800-891-2520