UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM

NOTE: THIS FORM IS NOT TO BE USED FOR PCA SERVICES.

BlueCross BlueShield Minnesota

Fax form and relevant clinical documentation to eviCore at **(866)506-3087**

To speak to an eviCore representative, call **(844)224-0494**

PLEASE NOTE: This form is NOT to be used for DHS FFS Home Health Services. It is to be used ONLY for Home Health Services covered by a health plan or a county-based purchasing plan.

In addition, this form is NOT to be used for PCA services. It is to be used ONLY for Home Health Services.

Date:_____ Start of Care Date:_____

Initial Authorization: ☐ **Continued Authorization:** ☐

Patient Information

Name:_____ Member Ins. ID:_____

Permanent Home

Address:_____

City, State, Zip:_____

Servicing address (if patient is at a different address): _____

City, State, Zip:_____

Primary Phone:_____ Secondary Phone: _____

Group # _____

DOB:_____

Primary Diagnosis for Home Care Services and ICD-10 Codes:_____

Other/Comorbid Diagnosis and ICD-10 Codes:_____

Homebound: YES ☐ NO ☐

Location of Service: Member Home ☐ Assisted Living ☐ Group Home ☐ Foster Care ☐ Customized Living ☐

Other: _____

Home Care Agency Information

Agency Name: _____ NPI: _____Tax ID#: _____

Address: _____City, State, Zip _____

Contact Name: _____

Contact Phone:_____ Contact Fax:_____

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MD/Ordering Provider Information

Name: _____ NPI: _____ Clinic: _____

Clinic Address:_____ City, State, Zip_____

Clinic/MD Contact Phone Number: _____ Fax number: _____

Date of last appointment: _____ Next visit date (If known):_____

Service Request Information:

Type of Service	Procedure Code	Number of Visits Requested	Frequency	Start Date (this request)	End Date (this request)

Clinical Information/Summary/Comments: [NOTE: Please attach the current CMS 485/Home care plan of care and clinical notes to support authorization request along with request.]

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Recent Hospitalization/Surgery: _____ D/C Date: _____