Home Health Services Authorization Request Form for Healthfirst Medicare Advantage Members in Queens, Brooklyn and Nassau Counties

** Note: Requests for Medical Suppies & Infusion Therapy should be faxed to Healthfirst for review

Fax all requests to eviCore: 855-826-3724

Call 877-773-6964 to speak with an eviCore representative.

***Note: eviCore will only be processing Home Health requests for Healthfirst members that had a stay in a PAC facility.**

Disclaimer statements and attestation

Authorizations will be given for medically necessary services only: it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract.

- **Verify eligibility and benefits prior to request. Home Health benefits verified?** ☐ **Yes** ☐ **No**
- **All therapy notes are within 24-48 hours of evaluation or last covered date?** ☐ **Yes** ☐ **No**
- **Member previously in a PAC facility?** ☐ **Yes** ☐ **No** **PAC DC Date:**_____

Person completing form, sign and date here:_____

Documents to attach: Clinical Progress Notes (for Certification requests) Therapy Notes (including level of participation (eval & last progress note) Medication list

☐ **Initial Request** ☐ **Continuation of Services**

MEMBER INFORMATION		
Member ID #:	**Last Name:**	**First Name:**
Phone Number:	**Date of Birth**	
Street Address:	**City, State, Zip Code:**	

ORDERING PROVIDER INFORMATION	
Last Name/First Name:	**NPI Number:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Fax Number:**
Provider Type/Specialty:	**Name of Requester:**

TREATING PROVIDER/VENDOR	
Home Health Agency Name:	**NPI Number:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Fax Number:**
Name of Requester:	

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healthfirst
Health Insurance for New Yorkers

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REQUEST FOR SERVICES			
Requested Dates of Service: **From:** **To:**		**Previous Authorization # (if continuation):**	
Original Start of Care Date:		**Number of Visits Rendered to Date for each discipline:** **RN PT OT ST**	
INSTRUCTIONS: Select the Discipline Requested and Enter the Quantity of Visits Needed			
Skilled Nursing ☐	**Times/ week for weeks**	**Physical Therapy** ☐	**Times/ week for weeks**
Occupational Therapy ☐	**Times/ week for weeks**	**Speech Therapy** ☐	**Times/ week for weeks**
Social Worker ☐	**Times/ week for weeks**	**Home Health Aide** ☐	**Times/ week for weeks**
Primary ICD10 Code(s):			
Secondary ICD10 Code(s):			