UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

S.OC. Date: ___/___/___ **Initial:** □ **Reauthorization**:___/___/___
Agency D/C Date:___/___/___: Anticipated □ Actual □ MD Agrees: Y/N Patient Agrees: Y/N

Patient Information
Name:_____
S.O.C. Address:_____
_____
Telephone #:_____
DOB:___/___/___
Homebound: Y/N Why?_____
Diagnosis:_____
Surgery: N/A_____
Patient Prognosis:
Poor / Guarded / Fair / Good / Very Good /
Excellent / <6 months to live / Terminal.
MD Information
Ordering MD:_____
MD Phone#:_____
PCP:_____
Date of Next MD Visit:___/___/___
Health Plan Information
Health Plan Name:_____
Insurance #:_____
Health Plan CM:_____
Initial Auth#:_____
Telephone #:_____Fax #:_____

Agency Information
Agency Name:_____
Provider Number:_____
Contact:_____
Telephone #:_____Fax#:_____
DME/Supplies/IV/Lab
Vendor Name:_____
Community Resources_____
_____
Caregiver Information
Name:_____
Relationship:_____
Type of Assistance:_____
Teachable/Not Teachable:_____
Primary Phone#:_____

Maternity Care N/A □
Delivery Date___/___/___Time Of Delivery__:__
Discharge Date___/___/___Time of Discharge__:__

Current Functional Status

Cognitive	Dress Lower Extremities	Bathing	Toileting	Ambulation
□Alert/Oriented	□ Independent	□ Independent	□ Independent	□ Independent
□ Impaired	□ Requires assist	□ Requires assist	□ Requires assist	□ Requires assist
□ Disoriented	□ Unable	□ Unable	□ Unable	□ Unable

Service Request	From	To	# Of Visits	Frequency	Auth # Visits	Health Plan Auth #
RN						
HHA/Hrs&Visits						
PT						
OT						
ST						
MSW						
Other						

Communication

Comments:_____
_____
_____
_____
_____
Name:_____**Title:**_____**Date:** ___/___/___

SKILLED NURSING D/C Date:___/___/___ Anticipated □ Actual □
Clinical summary: _____

Reason for Home Health Aide Services: _____

Wound Care N/A□	**Wound 1**	**Wound 2**	**Wound 3**
Location			
Appearance			
Measurement			
Drainage			
TX and Frequency			

Medications: Compliant: Y/N Teachable Patient: Y/N Med List Attached: NA/Y
Goals/Plan for this Authorization Period: _____

Barriers to Achieve Goals/Plan: _____

Interventions: _____

Signature: _____ **Title:** _____ **Department:** _____ **Date:** ___/___/___

OTHER SKILLED DISCIPLINES D/C Date: ___/___/___ Anticipated □ Actual □
Please complete a separate pg. 2 when more than one skilled discipline providing care
PT _____ **OT** _____ **ST** _____ **MSW** _____ **Other** _____
Reason for Home Health Aide Services: _____

Clinical summary? _____

Goals/Plan for this authorization period: _____

Barriers to achieve goals/plan: _____

Interventions: _____

Signature: _____ **Title:** _____ **Department:** _____ **Date:** ___/___/___