AULTCARE HOME HEALTH CARE SERVICES FORM

*****ALL FIELDS ARE MANDATORY AND REQUIRE COMPLETION FOR PROCESSING*****

*****NEW FORM MUST BE COMPLETED ,WITH EACH REQUEST*****

Priority: Standard

Last Name: **First Name:** **Date of Birth**

I.D. Number: **Group Number:**

Diagnosis: **ICD-10:**

CPT Codes:

Current Referral Number: **Is patient homebound?** ☐ **Yes** ☐ **No**
(if applicable, for continuation request)

Ordering Physician (Full Name):

Address: **Phone:**

Tax ID: **NPI:**

Requesting Agency:

Address: **Phone:**

Tax ID: **NPI:**

☐ **Skilled Nursing** ☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Speech Therapy**

☐ **Social Worker** ☐ **Home Health Aide** ☐ **Hospice** ☐ **Infusion**

Time period of visits being requested: **From** **To**

Professional making request: **# of visits requested**

Reimbursement Codes:

Homebound reasons (please be specific a diagnosis alone does not determine homebound status):

Have you uploaded supporting documentation? ☐ **Yes** ☐ **No**

****An updated treatment plan and progress notes must be submitted with request for continued services****

Note: A preauthorization does not guarantee payment or authorize coverage for services not covered through the member's benefit plan. Claims are subject to review upon receipt of the claim/documentation. Revised 5/20