

- Hospital/SNF Discharge
- PCP/Clinic Request



Continuing Service on
Authorization# _____

Home Health Prior Authorization Request

FAX: (855) 883-1552 www.goldcoasthealthplan.org Phone: (888) 301-1228

Date: _____

To facilitate the **prior authorization process**, the home health agency nurse must have completed the following tasks before contacting GCHP for prior authorization:

- Nursing evaluation of the member in the home (if additional visits are needed).
- Upon completion of this form, provide M.D. order and clinical notes.

<p>Member Name: _____</p> <p>CIN Number: _____ DOB: _____</p> <p>Member Current Phone #: _____</p> <p>Ordering Physician: _____</p> <p>Address: _____ Phone: _____</p> <p>City: _____ ST: _____ Zip: _____</p>	<p>Agency Name: _____</p> <p>Discharge Date: _____</p> <p>Initial Date of Service: _____</p> <p>Dates of Services: _____</p> <p>Date of Last Authorized Service: _____</p> <p>Additional visits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Total visits previously authorized? _____</p>
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- H & P or DC Summary
 M.D. Order
 Inpatient/Outpatient Rehab Notes

Skilled Nursing functions to be provided: _____

Pertinent Nursing Observations (prior teaching, size, and descriptions of wounds, functional limitations, etc.):

Availability and capabilities of caregiver(s): _____

*****List ALL procedures requested along with appropriate CPT code(s)*****

Diagnosis: _____ ICD-9: _____ ICD-10: _____

CPT/HCPCS Code(s)	Requested Procedure(s)	Quantity

Contact Nurse/Staff: _____ Phone: _____