**UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM**

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

PreferredOne®

Phone: 763-847-4477/800-997-1750

www.preferredone.com

## Please complete, print and fax this form and other relevant documents to (763) 847-4014.

**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:** ☐

**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) |
|---|---|---|---|---|---|
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**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: _____