



Advanced Health
289 LaClair St, Coos Bay, OR 97420
 Voice: 541-269-7400 • 800-264-0014
 Fax: 541-269-7147 • TTY: 877-769-7400

Home Health Authorization Request

• Fax Completed Form and chart notes to 541-269-7147 *PLEASE NOTE: INCOMPLETE FORMS WILL NOT BE PROCESSED*

Instructions to Complete Home Health Authorization Request:

- Requesting Provider is responsible to submitting all information in the top area of the form.
- Authorization requests must be accompanied with a signed Plan of Treatment/Evaluation. (Note: a current signed Prescribing Physician's prescription must be on file at the Home Health Agency's office for review upon request by Health Plan.)
- Follow-up requests for continuation of existing services must be made prior to expiration of current certification period.
- Recertification is required every 60 days from the initiation of treatment.
- Fax completed form, signed Plan of Care, and any other pertinent documentation to Health Plan's Medical Management Department at (541) 269-7147.
- If you have questions regarding this form or other related questions, please contact Health Plan's Medical Management Department at (541) 269-7400.

Member Name: _____ Medicaid ID #: _____ DOB: ____/____/____
 Home Health Provider: _____ PCP: _____
 Home Health Provider NPI#: _____
 ICD-10 Code(s): _____ Diagnosis(es): _____
*Required
 Certification Period *: From ____/____/____ to ____/____/____

Level of Care	# of Visits	Date Range
<input type="checkbox"/> Physical Therapy Visit (421)		____/____/____ to ____/____/____
<input type="checkbox"/> Occupational Therapy Visit (431)		____/____/____ to ____/____/____
<input type="checkbox"/> Home Health Aide Visit (571)		____/____/____ to ____/____/____
<input type="checkbox"/> Skilled Nursing Visit (551)		____/____/____ to ____/____/____
<input type="checkbox"/> Speech Language Pathology Visit (441)		____/____/____ to ____/____/____

Comments:

Person Completing Form: _____

Contact Person: _____

Phone: _____ Fax: _____

Date: ____/____/____

Disclaimer: Prior Authorization does not guarantee payment. Criteria is based on member eligibility on date of service, contract terms, and compliance with OAR rules, regulations and policies of CMS and Advanced Health.



Home Health Routing Slip

Member Name: _____ Authorization No. _____

Instructions:

- 1. Date and place your initials beside the item(s) being sent to Advanced Health along with a copy of this routing slip.
2. Fax forms to (541) 269-7147
3. Place copies in patient's chart

A. Initial 60 day episode of care:

Dates: ____/____/____ to ____/____/____

- 1. Copy of signed referral/order form
2. Copy of Plan's authorization form
3. Signed PPOT (CMS 485)
4. MD order (fax or order slip) for other discipline(s) and

Signed evaluation of ordered discipline _____ 5. Signed PPOT Addendum (CMS 487)

_____ 6. Opening evaluation notes

B. Recertification for subsequent 60 day episode of care:

Dates: ____/____/____ to ____/____/____

- 1. Copy of signed PPOT (CMS 485)
2. Copy of Plan's authorization form
3. Copy of order for other discipline(s) and signed

evaluation of ordered discipline. _____ 4. Copy of signed PPOT Addendum (CMS 487)

C. Resume - Is in 60 day episode of care:

Dates: ____/____/____ to ____/____/____

- 1. Copy of signed referral/order form
2. Copy of signed Resume orders

D. Significant change in condition - Is in 60 day episode of care:

Dates: ____/____/____ to ____/____/____

- 1. Copy of orders
2. Copy of signed evaluation of ordered discipline, if applicable
3. Copy of signed MD orders