University Hospitals | Medicare Advantage Plan by PTHP

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UNIVERSITY HOSPITAL MEDICARE ADVANTAGE PLAN by PTHP
HOME HEALTH CARE SERVICES FORM

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

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

Patient: _____ **Date of Birth:** _____

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

Diagnosis: _____ **ICD-9/ICD-10:** _____

Current Referral Number: _____ **Is patient homebound?** _____**Y** _____**N**

(If applicable, for continuation request)

Ordering Physician (Full Name): _____

Address: _____ **Phone:** _____

Tax ID: _____ **NPI:** _____

Requesting Agency: _____

Address: _____ **Phone:** _____

Tax ID: _____ **NPI:** _____

Actual Visits Requested:

_____**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 Reason: (Please be specific, a diagnosis alone does not determine homebound status):

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.