AULTCARE'S PRIMETIME HEALTH PLAN

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PRIMETIME HEALTH PLAN
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.