

DATE: \_\_\_\_\_

FAX TO: 502-585-8204

ATTN: PASSPORT HEALTH PLAN HOME HEALTH



# HOME HEALTH AUTHORIZATION FORM

MEMBER'S NAME \_\_\_\_\_

PHP ID \_\_\_\_\_ MEMBER'S DOB \_\_\_\_\_

AUTHORIZATION NUMBER \_\_\_\_ - \_\_\_\_ - \_\_\_\_

DIAGNOSIS \_\_\_\_\_ ORDERING MD \_\_\_\_\_

DISCIPLINE AND NUMBER OF VISITS REQUESTED FOR EACH:

RN \_\_\_\_ HH \_\_\_\_ PT \_\_\_\_ OT \_\_\_\_ ST \_\_\_\_ SW \_\_\_\_ RD \_\_\_\_

DATES OF SERVICE: FROM \_\_\_\_\_ TO \_\_\_\_\_

DISCIPLINE AND NUMBER OF VISITS APPROVED FOR EACH:

RN \_\_\_\_ HH \_\_\_\_ PT \_\_\_\_ OT \_\_\_\_ ST \_\_\_\_ SW \_\_\_\_ RD \_\_\_\_

DATES OF SERVICE: FROM \_\_\_\_\_ TO \_\_\_\_\_

WHY ARE VISITS NEEDED? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT WOUND MEASUREMENTS

\_\_\_\_\_  
\_\_\_\_\_

CURRENT LAB RESULTS

PROVIDER ID \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

REQUESTING AGENCY \_\_\_\_\_

AGENCY PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

PHP PERSON AUTHORIZING \_\_\_\_\_

DATE AUTHORIZED \_\_\_\_\_