HOME HEALTH COMMUNICATION FORM

Form must be completed by UCare Care Coordinator.

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.

Fax form to 612-884-2499 or
Email to hcm_fax@ucare.org.

For questions, **call** 612-676-6705 or
toll free 866-610-7215.

MEMBER INFO	
Member Name ______________________	**Member ID** ______________
PMI ______________________	**DOB** ______________
ICD-10 ______________________	
CC INFO	
Care Coordinator Name ______________________	**Phone Number** ______________
Email ______________________	**Fax** ______________
ATTENDING HEALTH CARE PROFESSIONAL INFO	
Clinician Name ______________________	
Clinic Name ______________________	
Address ______________________	**City, State, Zip** ______________
Phone ______________________	**Fax** ______________

HH (Home Health) Services -

- Use this form to **reduce/terminate** home health services such Home Health Aide (HHA), Home Health Aide Extended (HHA Ext), or Skilled Nurse Visits (SNV). CM should ensure coordination to reduce or terminate services is communicated with Home Care Agency.
- Use this form to **request** Elderly Waiver Extended HHA (T1004.).
  Extended HHA: Extended home care services follow state plan home care policies, but allow the services to exceed the limits on amount, duration and frequency. HHA provides medically oriented task(s) to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence. Only one visit per day per person is permitted for HHA.

SERVICES REQUESTED	**HH SERVICES**	
	Service Description ______________________	
	Frequency ______________________	
	Start Date ______________________	End Date ______________
	PCA Provider Name ______________________	PCA Provider UCare ID ______________
	Phone ______________________	Fax ______________
	Detailed description of reason for request:	