Clear Form

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 Mr. X **Member ID** 000-0000000

PMI XXXXX **DOB** 1/1/10

ICD-10 J-010x

CC INFO

Care Coordinator Name Sally J **Phone Number** 612-000-0000

Email SallyJ@XXXX.org **Fax**

ATTENDING HEALTH CARE PROFESSIONAL INFO

Clinician Name Dr. X

Clinic Name X clinic

Address 1 Apple Ave. **City, State, Zip** Mpls, MN

Phone 612-xxx-xxxx **Fax** 612-xxx-xxxx

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 Terminate Extended HHA

Frequency 2x/week

Start Date 12/1/18 End Date

PCA Provider Name PCA XXX PCA Provider UCare ID XXXXXX

Phone 612-XXX-XXXX Fax 612-XXX-XXXX

Detailed description of reason for request:

Terminate extended HHA due to member getting other services