UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision.

Fax form and any relevant clinical documentation to: 612-884-2257

For questions:
call: 612-676-3300

Submit request:
E-mail: Homecare@ucare.org

PLEASE NOTE: This form is NOT to be used for PCA Services or DHS FFS Home Health Services. It is to be used ONLY for Home Health Services covered by a health plan or a county-based purchasing plan.

UCare Connect and UCare Connect + Medicare Authorization: Submit current CMS-485/Care Plan & 2 recent visit/progress notes for continue authorization or CMS-485/Physician Orders for initial/start of care. If on a waiver, contact member's county case manager. If not on a waiver, submit documentation as listed above.

Date:_____ Start of Care Date:_____

Initial Authorization: ☐ **Continued Authorization:** ☐

Patient Information

Name:_____ Member Ins. ID:_____

Permanent Home

Address:_____

City, State, Zip:_____

Servicing address (if patient is at a different address): _____

City, State, Zip:_____

Primary Phone:_____ Secondary Phone: _____

Group # _____

DOB:_____

Primary Diagnosis for Home Care Services and ICD-10 Codes:_____

Other/Comorbid Diagnosis and ICD-10 Codes:_____

Homebound:

Location of Service: Member Home ☐ Assisted Living ☐ Group Home ☐ Foster Care ☐ Customized Living ☐

Other: _____

Home Care Agency Information

Agency Name: _____ NPI: _____ Tax ID#: _____

Address: _____ City, State, Zip _____

Contact Name: _____

Contact Phone:_____ Contact Fax:_____

ucare

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NOTE: THIS FORM IS NOT TO BE USED FOR PCA SERVICES.

MD/Ordering Provider Information

Name: _____ NPI: _____ Clinic: _____

Clinic Address: _____ City, State, Zip: _____

Clinic/MD Contact Phone Number: _____ Fax number: _____

Date of last appointment: _____ Next visit date (If known): _____

Service Request Information:

Type of Service	Procedure Code	Number of Visits Requested	Frequency	Start Date (this request)	End Date (this request)

Clinical Information/Summary/Comments: [NOTE: Please attach the current CMS 485/Home care plan of care and clinical notes to support authorization request along with request.]

Recent Hospitalization/Surgery: _____ D/C Date: _____