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: 612-884-2499 or 1-866-610-7215

For questions, **call**: 612-676-3300 or 1-888-531-1493

Submit request: UCare's Secure E-mail Site
E-mail: HCM_Fax@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:____________________________

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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: _______________________