☐ Hospital/SNF Discharge

☐ PCP/Clinic Request

☐ Continuing Service on

Authorization#_____

Home Health Prior Authorization Request

FAX: (855) 883-1552 www.goldcoasthealthplan.org Phone: (888) 301-1228

Date:_____

To facilitate the **prior authorization process**, the home health agency nurse must have completed the following tasks before contacting GCHP for prior authorization:

- Nursing evaluation of the member in the home (if additional visits are needed).
- Upon completion of this form, provide M.D. order and clinical notes.

Member Name:_____

CIN Number:_____ **DOB:**_____

Member Current Phone #:_____

Ordering Physician:_____

Address:_____ **Phone:**_____

City:_____ **ST:**_____ **Zip:**_____

Agency Name:_____

Discharge Date:_____

Initial Date of Service:_____

Dates of Services:_____

Date of Last Authorized Service:_____

Additional visits? ☐ **Yes** ☐ **No**

Total visits previously authorized?_____

☐ **H & P or DC Summary** ☐ **M.D. Order** ☐ **Inpatient/Outpatient Rehab Notes**

Skilled Nursing functions to be provided:_____

_____

_____

Pertinent Nursing Observations (prior teaching, size, and descriptions of wounds, functional limitations, etc.):

_____

_____

_____

_____

Availability and capabilities of caregiver(s):_____

_____

******List ALL procedures requested along with appropriate CPT code(s)******

Diagnosis:_____ ***ICD-9:***_____ ***ICD-10:***_____

_____ _____

CPT/HCPCS Code(s)	Requested Procedure(s)	Quantity

Contact Nurse/Staff:_____ **Phone:**_____

Revised July 30, 2015