Optum

Home Health Care Prior Authorization Intake Request Form

General Authorization Information

***Patients Name:** _____ **DOB:** _____

***Please select the nature of your request:**

- ☐ Initial SOC notification (days 1-14)
- ☐ SOC authorization request to continue services (days 15-60)
- ☐ Recert request for continuation of services. If yes, which cert period, 2__3__ 4__ or more___
- ☐ Add additional visits or disciplines to an approved and open authorized certification period
- ☐ Resumption of care. Date of hospitalization: _____

***Initial Start of Care (SOC) date:** _____

***Cert period dates being requested:** _____

***Please select each discipline and note the number of visits being requested (orders supporting these visits are required for review)**

- ☐ SN/ # of visits ____ SN need is for: _____
- ☐ PT/ # of visits ____
- ☐ OT/ # of visits ____
- ☐ ST/ # of visits ____
- ☐ HHA/# of visits ____
- ☐ MSW/ # of visits ____ (Greater than 2 MSW visits will require medical director review)

*If number of visits requested exceed the number of ordered visits, may we change the amount of visits to match the plan of care? Yes_____ No_____

***Date of last Face to Face encounter with ordering/certifying physician**: _____

***Please submit the most up-to-date Plan of care, OASIS, 485, current evaluation(s), and/or visit notes to support the requested service(s)**