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### Home Health Authorization Request

\*Indicates a required field

**Requirements:** Clinical information and supportive documentation should consist of current physician order, notes and recent diagnostics. **Notification is required for any date of service change.** **Expedited Requests:** If the standard time for making a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call 1-888-588-9842.

Fax completed form to 1-866-886-4321

Requestor Name: \_\_\_\_\_ Fax\*: \_\_\_\_\_ Phone\*: \_\_\_\_\_

MEMBER INFO (Please Print)				
WellCare ID*:		Medicaid/Medicare ID:		
Last Name*:	First Name, MI*:		Date of Birth*:    /    /	
REQUESTING PROVIDER (Please Print)				
WellCare ID:		NPI/Tax ID*:		
Provider Name*:		Address:		
City, State, ZIP:		Fax*:	Phone:	
HOME HEALTH AGENCY (Please Print)				
WellCare ID:		<input type="checkbox"/> Plan to Assign	NPI/Tax ID*:	
Provider Name*:		Address:		
City, State, ZIP:		Fax*:	Phone:	
REQUESTED SERVICES* (Please Print)				
**PT, OT and other Home Health Services may be delegated to Evicore or Coastal Care, please check the QRG**				
Are services needed for discharge planning? (circle one)    Y / N			Discharge Date: ____ / ____ / ____	
ICD-10 Code*:	ICD-10 Code:	ICD-10 Code:	ICD-10 Code:	
Service Requested*	Procedure Code*	Start Date*	End Date	Frequency
Skilled Nursing				____ days a week for ____ weeks = ____ visits
Home Health Aid				____ days a week for ____ weeks = ____ visits
MSW (Social Worker)				____ days a week for ____ weeks = ____ visits
Physical Therapy				____ days a week for ____ weeks = ____ visits
Occupational Therapy				____ days a week for ____ weeks = ____ visits
Speech Therapy				____ days a week for ____ weeks = ____ visits
Episode of Care (Medicare Only) – No codes required				____ days a week for ____ weeks = ____ visits

\*\*Some services may be delegated to EviCore or Coastal Care. Please check the QRG\*\*