HEALTH OPTIONS AUTHORIZATION REQUEST FOR HOME HEALTH RN VISITS
Fax to 1-855-451-6667

Home Health Provider Name: _____

Phone Number: _____

Fax from Name: _____

Member Name: _____

Request Type: ☐ New ☐ Ongoing Authorization # _____

Number of Visits Requested (include frequency and duration): _____

Reason for Request: Provide detailed update to support request:

- ☐ **Bladder:** _____
- ☐ **Bowel:** _____
- ☐ **CV:** _____
- ☐ **Diabetes:** _____
- ☐ **Hematology:** _____
- ☐ **Injections:** _____
- ☐ **Neuro:** _____
- ☐ **Pain Management:** _____
- ☐ **Peripheral Vascular:** _____
- ☐ **Psychiatric:** _____
- ☐ **Resp:** _____
- ☐ **Wound** (include all wounds, measurements, description and treatment):
  _____
- ☐ **Other**: _____

Home Setting/Teaching or Discharge Goals:
(include support system and self care info):

_____

_____

_____

_____

Next Physician Appointment: _____