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

Home Health Provider Name: _____

Phone Number: _____

Fax from Name: _____

Member Name: _____

Request Type: ☐ New ☐ Ongoing Authorization # _____

For New Request: Please complete the following information:

Member ID: _____

Member Name: _____

Ordering MD: _____

Diagnosis: _____

Reason for Home Health Aide: _____

Home Environment: _____

Family/Support: _____

For ongoing request, please include auth number and name as requested above
Reason for ongoing home health aide visits:

_____

_____

_____

_____

_____

_____

Number of Visits Requested and Timeframe

Therapy Number of Visits: _____ Start Date: _____ End Date: _____

DISCHARGE PLAN FOR HOME HEALTH AIDE:

Estimated Date for Discharge From Services: _____