HIGHMARK. HEALTH OPTIONS

Home Health Aide (HHA) Shifts Prior Authorization Request Form

Complete and fax all requested information below including any supporting documentation as applicable to Highmark Health Options at **1-855-445-4239**. **Authorization is based on medical necessity. Incomplete information or illegible forms will delay processing.**

Questions or concerns? Call Utilization Management at 1-844-325-6251, Monday through Friday, 8 a.m. to 5 p.m.

Date: _____

Member Information		
Member Name	**Member ID**	**Date of Birth**
Caregiver Name	**Caregiver Phone**	
Diagnosis	**ICD-10 Code**	**HCPCS Code**

Type of Request	
Initial HHA Request? ☐ Yes ☐ No	**Follow Up HHA Review?** ☐ Yes ☐ No
Change in Medical Condition or Needs? ☐ Yes ☐ No	**If other, explain:**
Is the member currently or recently hospitalized? ☐ Yes ☐ No	**Discharge Date**

Indicate if the HHA hours are requested for:		
Work ☐ Yes ☐ No	**School or Daycare** ☐ Yes ☐ No	**Before/After School Care** ☐ Yes ☐ No

Indicate Days Per Week and Number of Hours Per Day HHA Services are Requested	
☐ **Sunday**	**Number of hours per day requested:** _____
☐ **Monday**	**Number of hours per day requested:** _____
☐ **Tuesday**	**Number of hours per day requested:** _____
☐ **Wednesday**	**Number of hours per day requested:** _____
☐ **Thursday**	**Number of hours per day requested:** _____
☐ **Friday**	**Number of hours per day requested:** _____
☐ **Saturday**	**Number of hours per day requested:** _____
☐ **Non-School Days (e.g., in-services, closures)**	**Number of hours per day requested:** _____

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Required Past Medical History (Attach additional documentation as needed)

Home Health Aide Needs

Describe the activities of daily living (ADL) needs that the HHA would provide during the hours requested.

Assessment of Member's Activities of Daily Living (ADL) Functions

	Independent	Supervision	Minimal Assistance	Moderate or Maximum Assistance	Dependent
Bathing					
Grooming					
Dressing					
Toileting					
Bed mobility					
Transfers					
Eating					

Include any additional information and documentation to support the requested hours.

Durable Medical Equipment (DME) Related to ADL Care

List DME.

Additional Information

Provide any additional information and documentation to support member's requested hours.

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Services Requested for School and School Bus Transportation

This section requires accompanying documents to support the request. Include the following documents:

- A copy of this member's current Individualized Education Plan (IEP).
- School calendar for the current school year.
- Bus schedule with drop-off and pickup times, if applicable.

Name of School	
Name of School Nurse	**Phone**
If possible, explain member's required ADL needs while in transport or school that cannot be met by services provided by transportation or school.	

Caregiver Information

List all responsible caregivers in the home. Briefly describe caregiver and caregiver work, school, and medical conditions that limit the availability and duration of the caregiver to care for the member. Include backup caregiver information.

Please submit all that apply regarding caregiver's availability:

- **Submit work verification from caregiver's employer noting what hours the caregiver is expected to work.**
- **Submit documentation from caregiver's school registrar's office verifying enrollment and class schedule.**
- **Submit documentation from caregiver's doctor outlining caregiver's disability, including prognosis and expected duration of the limitation.**

Signature and Attestation

Ordering Provider Name	**NPI Number**
Facility/Practice Name	
Provider Address	
Provider Phone:	**Provider Fax**
I hereby attest the information included in this document is true, accurate, and complete to the best of my knowledge. Additionally, I deem that the services requested are medically necessary. (Parental requests can be considered in making medical necessity determinations, however, this request is made under your signature and is similar in nature to a prescription for medication; your professional judgment for the need of a prescription medication is not predicated on patients' requests but medical need. In addition, requests that are in excess of that which are medically necessary are subject to Centers for Medicare & Medicaid Services' fraud, waste, and abuse policies and could carry associated penalties).	
Provider Signature	**Date**