

PRIOR AUTHORIZATION



Medicare Advantage Home Health Care fax request form

Providers: you must get Prior Authorization (PA) for HHC. PA is not guarantee of payment. Payment is subject to coverage, patient eligibility and contractual limitations. Please use appropriate form for DME and Generic PA requests.

Date ____/____/____

Please check request type

☐ Concurrent Review request

☐ Requests-May take up to 72 hours.

I certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Provider signature required

Patient name
And phone number

Requesting provider

Provider NPI #

Patient ID #

HHC Agency

HHC NPI #

Patient birthdate

Contact name

Initial care start date

Contact phone #

Contact fax #

Was patient discharged from hospital in past 30 days?

☐ No

☐ Yes, patient was discharged on ____/____/____ Facility name _____

Attending physician _____ Attending physician phone # _____

Is patient homebound?

☐ No ☐ Yes. Please provide supporting documentation.

ICD-10 code

ICD-10 code

ICD-10 code

ICD-10 code

ICD-10 code

Able/Willing teachable Caregiver? ☐ Yes ☐ No If No Explain:

Request Date:

Start of Care Date:

OR

Last Covered Day:

What is being Requested?

☐ Initial Request

☐ Extension

☐ Recertification

Please submit the following Clinical Documentation:

- SOC Recertification/Resumption Oasis Documents (as applicable) and Therapy Evaluations
- 485/Orders
- Wound Notes
- Supporting Clinical Documentation (Clinical visit notes from last 14 days, Physician progress notes, H&P, Hospital Discharge, etc...)
- Include NOMNC/Discharge Summary/for customer discharged from HH in last 60 days
- Discharge/Transfer Oasis and NOMNC

Please provide total # of visits that have already been completed

	RN	PT	OT	ST	MSW	HHA
# of visits already completed						
Dates of Service						

Home Health Services Requested	Services Providing
☐ Skilled Nursing Plan of Care Frequency:	☐ Wound Care ☐ Foley or PEG care ☐ Access Care ☐ Skilled Teaching ☐ Injections/Infusion ☐ Other
☐ PT ☐ OT ☐ ST (All therapy requests should include current level of function and goals/progress toward goals) Plan of Care Frequency:	☐ Evaluation and Treatment ☐ Maintenance Therapy
☐ HHA/MSW Plan of Care Frequency:	Initial Assessment of qualifying Service must be attached

Please fax this form and supportive clinical to Pre-Cert department below by market:

Market	Phone #	Fax #
IL, IN, No. MS, No. GA, AR	800.453.4464	866.287.5834
AL, FL, NC, SC, So. MS, Atlanta	800.962.3016	800.872.8685
TX, AR, OK	832.553.3456	888.205.8658
MA, PA, DE, DC, KC	888.454.0013	800.931.0145
TN HHC	866.913.0947	855.761.7326 or 615.401.4667

For a list of Cigna Medicare Advantage services requiring PA, visit medicareproviders.cigna.com or call your state's Pre-Cert Department.