Medica

UNIVERSAL HEALTH PLAN/HOME HEALTH AGENCY PRIOR AUTHORIZATION REQUEST FORM

- **Please note: this form is NOT to be used for MSHO/MSC+ or SNBC members: please contact the members Care Coordinator for authorization**
- **This form is only used for Home Health Services – this is NOT to be used for PCA Services**

Date:_____ Start of Care Date:_____

Initial Authorization: Y/N Continued Authorization: Y/N

Patient Information

Name:_____ Member Ins. ID:_____

Permanent Home

Address:_____

City, State, Zip:_____

Servicing address (if patient is at a different address): _____

City, State, Zip:_____

Primary Phone:_____ Secondary Phone: _____

Group # _____

DOB:_____

Primary Diagnosis for Home Care Services and ICD-10 Codes:_____

Other/Comorbid Diagnosis and ICD-10 Codes:_____

Homebound: Y/N

Location of Service: Member Home ___ Assisted Living ____ Group Home ____ Foster Care ____ Customized Living ____

Other: _____

Home Care Agency Information

Agency Name: _____ NPI: _____Tax ID#: _____

Address: _____City, State, Zip _____

Contact Name: _____

Contact Phone:_____ Contact Fax:_____

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NOTE: THIS FORM IS NOT TO BE USED FOR PCA SERVICES.

MD/Ordering Provider Information

Name: _____ NPI: _____ Clinic: _____

Clinic Address:_____ City, State, Zip_____

Clinic/MD Contact Phone Number: _____ Fax number: _____

Date of last appointment: _____ Next visit date (If known):_____

Service Request Information:

Type of Service	Procedure Code	Number of Visits Requested	Frequency	Start Date (this request)	End Date (this request)

Clinical Information/Summary/Comments: [NOTE: Please attach the current CMS 485/Home care plan of care and clinical notes to support authorization request along with request.]

_____

_____

_____

_____

Recent Hospitalization/Surgery: _____ D/C Date: _____

Submission of this completed form certifies that the information is true and accurate. All fields are required for processing your request.Submit form by

- For groups that begin with IFB or C: Fax to 952-992-2836 or email to ifbhealthmanagement@medica.com
- For groups that begin with A **(excluding A0061 & A00500)**: Fax to 952-992-2396 or email to hpshealthmanagement@medica.com
- For all other group numbers **(including A0061 & A00500):** Fax to 952-992-3556 or email to caremanagement@medica.com
- U.S. Mail to Medica, Utilization Management, PO Box 9310, CP440, Minneapolis, MN 55440