Fax to:
1-888-282-0780 - Commercial Members
1-800-447-2994 - Medicare Advantage (alpha prefix XXC)
1-888-282-1315 - Federal employees (alpha prefix R)

UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

S.O.C. Date: ___/___/___ **Initial:** ____ **Reauthorization**:___/___/___
Agency Discharge Date:___/___/___ **MD Agrees**: Y/N **Patient Agrees**: Y/N

Patient Information
Name:_____
S.O.C. Address:_____
_____
Telephone #:_____
DOB:___/___/___
Homebound: Y/N Why?_____
Diagnosis:_____
Surgery: N/A_____

MD Information
Ordering MD:_____
MD Phone #:_____
PCP:_____
Date of Next MD Visit:___/___/___

Health Plan Information
Health Plan Name:_____
Insurance #:_____
Health Plan CM:_____
Initial Auth#:_____
Telephone #:_____Fax #:_____

Agency Information
Agency Name:_____
Provider Number:_____
Contact:_____
Telephone #:_____Fax#:_____

DME/Supplies/IV/Lab
Vendor Name:_____

Community Resources_____
_____

Caregiver Information
Name:_____
Relationship:_____
Type of Assistance:_____
Teachable/Not Teachable:_____
Primary Phone #:_____

Maternity Care N/A ❒
Delivery Date___/___/___Time Of Delivery__:__
Discharge Date___/___/___Time of Discharge__:__

Current Functional Status

Cognitive	Dress Lower Extremities	Bathing	Toileting	Ambulation
❒Alert/Oriented	❒ Independent	❒ Independent	❒ Independent	❒ Independent
❒ Impaired	❒ Requires assist	❒ Requires assist	❒ Requires assist	❒ Requires assist
❒ Disoriented	❒ Unable	❒ Unable	❒ Unable	❒ Unable

Service Request	From	To	# Of Visits	Frequency	Auth # Visits	Health Plan Auth #
RN						
HHA/Hrs&Visits						
PT						
OT						
ST						
MSW						
Other						

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 Patient Name:_____ **Agency**:_____

Return Communication

Comments:_____
_____
_____
_____
_____
Name:_____ **Title:**_____ **Date:** ___/___/___

SKILLED NURSING Anticipated D/C Date:___/___/___
Pertinent Disease Specific Data:_____
_____
_____
_____
_____
Home Health Aide Services:_____

Wound Care N/A❒	**Wound 1**	**Wound 2**	**Wound 3**
Location			
Appearance			
Measurement			
Drainage			
TX and Frequency			

Medications: Compliant: Y/N Teachable Patient: Y/N Med List Attached: NA/Y/N
Interventions and Educational Plan: _____
_____
_____
Short-Term Goals:_____
_____
_____
Long -Term Goals:_____
_____
_____
Barriers:_____
_____

Signature: **Title:** **Department:** **Date: / /**

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 Patient Name:_____ **Agency**:_____

OTHER SKILLED DISCIPLINES Anticipated D/C Date: ___/___/___
Please complete a separate pg. 2 when more than one skilled discipline providing care
PT _____ **OT**_____ **ST**_____ **MSW** _____**Other**_____
Home Health Aide Services:_____
Pertinent Disease Specific Data:_____
_____
_____
Interventions and Educational Plan:_____
_____
Short-Term Goals: _____
_____
_____
Long-Term Goals:_____
_____
_____
Barriers:_____
_____

Signature: **Title:** **Department:** **Date:** / /