

**For Blue Cross Blue Shield of Massachusetts members, 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)  
 Authorization is only required for out-of-network requests.

## 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
<input type="checkbox"/> Alert/Oriented	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> Impaired	<input type="checkbox"/> Requires assist	<input type="checkbox"/> Requires assist	<input type="checkbox"/> Requires assist	<input type="checkbox"/> Requires assist
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> 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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