

Authorization Form
Palliative Care
Fax Form To: 616 975-8885
Attn: Home Health Care



Please complete all fields pertinent to your request to ensure timely processing. Please do not fax additional documentation unless requested.

Member

Member's Name: _____ ID #: _____ DOB: _____

Ordering Physician: _____ Following Physician: _____

Palliative Care Agency: _____ Tax ID#: _____

Contact: _____ Phone: _____

Place of Service: _____

All Diagnoses/ICD-9: _____

Start Date: _____ Discharge Date: _____

Visits Requested

RN	_____	+	_____	=	_____	Physician	_____	+	_____	=	_____
OT	_____	+	_____	=	_____	Speech	_____	+	_____	=	_____
PT	_____	+	_____	=	_____	MSW	_____	+	_____	=	_____
HHA	_____	+	_____	=	_____						

Auth will be put in for a 2 month time span, then updates required. Please complete information below for re-auth.

Symptom Management Update

Emergency Department Usage

Acute Care Hospitalizations

Advance Care Planning Updates

Specific Interventions

Discharge Plans

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