

Authorization Form
Home Health Care Services Requests
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: _____ ICD-9: _____

HHC Agency: _____ Tax ID#: _____

Contact: _____ Phone: _____

Start Date: _____ End Date: _____

DME Provider: _____ Tax ID#: _____

(if primary nursing service is wound care)

Is the member homebound? Yes No

Visits Requested:

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

(total # of weeks)

Additional Information:

	Independent	Supervision	One Assist	Dependent
ADL's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation Distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Non	Partial	Full
Weight Bearing Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Poor	Fair	WNL
Range of Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Recent falls or falls since last visit?	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Safety Concerns	<input type="checkbox"/>	<input type="checkbox"/>

Wound Measurements	<hr/>	
Can wound care be taught?	<input type="checkbox"/>	<input type="checkbox"/>

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