NORTHCOAST HEALTH CARE MANAGEMENT Services, Ltd.

ANTHEM MEDICARE ADVANTAGE HOME HEALTH CARE INITIAL AUTHORIZATION REQUEST

FAX THIS FORM WITH REQUIRED INFORMATION TO: **216-591-2502**
or via secure email to: **intakefax@northcoastgroup.org**
Questions? Call 800-757-7111, option 1

Request Type

Date:

☐ Standard Request: Within protocol guidelines

☐ Outside Guidelines: **Backup must be attached for all requests outside standard guidelines listed below. Please be aware that all non-standard requests will be delayed.**

☐ Urgent Request:

By signing below, I certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Urgent Requests may take up to (24) hours.

Signature: _____

SUBMIT THIS FORM AND REQUIRED DOCUMENTATION NO LATER THAN START OF CARE DATE

Member Name:	**HHC Name:**
Member ID#: **DOB:**	**BRANCH:**
Post Hospital Discharge: Yes ☐ No: ☐	**Contact Name:**
Date:	**Phone:** **Fax:**
Start of Care Date:	**Ordering MD:**
Diagnosis (incl. Codes):	**Sub-Type Protocol:** _____

HOMEBOUND STATUS:
Yes: ☐ **No:** ☐

CMS homebound definition: *MD certifies patient requires assistance or is medically contraindicated; and requires considerable and taxing effort to leave home. Absences are infrequent/short duration or attributable to the need for health care treatment.*

What is Being Requested *(place dates of service beside each discipline you are requesting).*	**Reason for visits** *(please attach current clinical related to reason)*
Skilled Nursing *(incl wound measurements, name/dosage frequency of medications if appl.)* #Visits: _____ Dates: _____	☐ Wound Care ☐ Foley or PEG care ☐ Access Care (port/PICC) ☐ Teaching/Compliance ☐ Injections ☐ Other:
PT *(all therapy requests should include current level of functions and goals)* #Visits: _____ Dates: _____	☐ Home Assessment ☐ Exercise/Strengthening ☐ AD/Equipment Training ☐ Energy Conservation ☐ Home Exercise Program ☐ Other ☐ Safety
OT #Visits: _____ Dates: _____	☐ Strengthening ☐ Safety Other
ST #Visits: _____ Dates: _____	☐ Communication ☐ Other ☐ Cognitive ☐ Swallowing
HHA #Visits: _____ Dates: _____	☐ Assist with ADL's ☐ Functional impairment ☐ Other: _____
MSW #Visits: _____ Dates: _____	
Able/willing/teachable caregiver? If no, please explain	
D/C Plan (discharge planning begins at admission, visits approved may include 2 visits to issue NOMNC):	

REQUIRED INFORMATION:

please check included items

☐ **MD Home Healthcare signed or verbal order**

☐ **History and Physical if applicable**

☐ **Wound Care Pictures/Notes (if available)**

☐ **Additional Notes**

☐ **Back-up for Non Standard Request**

Select Appropriate Sub-Type Applicable to Diagnoses

Sub-Type	SN	PT	OT	ST	MSW	HHA	Total
General	5	4	1	0	0	2	12
THR/TKR	2	9	4	0	0	2	17
Wound General	8	0	0	0	0	0	8
Wound Vac	12	0	0	0	0	0	12
Foley	1	0	0	0	0	0	1
B12	1	0	0	0	0	0	1
CVA	4	12	2	1	0	0	19
CHF	5	6	0	0	0	0	11
COPD	5	6	0	0	0	0	11
Diabetes	8	0	0	0	0	0	8
Sepsis	9	0	0	0	0	0	9
Neuromuscular Restorative	3	8	4	0	0	0	15
Neuromuscular Maintenance	1	5	0	0	0	0	6
UTI	5	0	0	0	0	0	5
CABG	5	6	0	0	0	0	11
Chemo	5	0	0	0	0	0	5