Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

The purpose of this form is to request a Home Health prior authorization. Request must be submitted within 5-7 days of EACH 30-day period of care. Please fax this completed form to (318) 812-6265. Requests **without** supporting clinical documentation will be returned to the provider, delaying the review process.

If you have questions about this form, contact Blue Advantage Medical Management at 1-866-508-7145, option 3, option 3.

Please complete all applicable areas below.

Home Health Authorization Request Form

TYPE OF REQUEST

☐ Initial 30-day Request

☐ Additional 30-day Request(s)

Dates of Service Requested ____/____/______ - ____/____/______	PDGM/HIPPS ________________________

PATIENT INFORMATION

Name	Date of Birth
Member ID Number	Phone Number
Address	

ADMISSION/AGENCY INFORMATION

Agency Name	NPI
Phone Number	Fax Number
Contact Name	Contact Phone Number
Agency Address	
Physician Name	Physician NPI
Physician Phone Number	Physician Fax Number
Physician Address	

ADMISSION SOURCE AND TIMING

Institutional ☐	Community ☐
Early ☐ Late ☐	Early ☐ Late ☐

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

Inpatient Facility	Date of Face to Face Visit
Dates of Service	Last MD Visit

MEDICAL INFORMATION

Primary Diagnosis Description	ICD-10 Code	CPT®/HCPCS Code(s)
Secondary Diagnosis/Diagnoses Description (if applicable)	ICD-10 Code(s)	CPT®/HCPCS Code(s)

Pursuant to federal guidelines for home health code assignment and clinical criteria, check the appropriate box for clinical documentation/records that are attached for review:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Progress Notes
- ☐ Face to Face medical office notes with homebound status confirmed
- ☐ Other – Explain:

(Attached documentation must demonstrate the clinical need for home health services)

CURRENT HOMEBOUND/FUNCTIONAL STATUS

CAREGIVER AVAILABILITY

Name:	☐ No Available Caregiver
Relationship	Teachable ☐ Yes ☐ No If no, explain:

30-DAY FREQUENCY

☐ Skilled Nurse ____________________	☐ Home Health Aide _________________
☐ Physical Therapy _________________	☐ Occupational Therapy _____________
☐ Speech Therapy __________________	☐ MSW ___________________________

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CLINICAL SUMMARY

Provide current care plan, interventions, progress toward goals, medications, wounds and any identified barriers to care:

Completed by_________________________________Title_____________Date____________

Clinical Records Attached: ☐ Yes ☐ No

If no, provide detailed explanation:

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