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 Authorizations Department at 1-866-508-7145, choose option 3, then 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	Tax ID
Phone Number	Fax Number	
Contact Name	Contact Phone Number	
Agency Address		
Physician Name	Physician NPI	Physician Tax ID
Physician Phone Number	Physician Fax Number	
Physician Address		

ADMISSION SOURCE AND TIMING

Institutional	Community
Early Late	Early Late
Inpatient Facility	Date of Face-to-face Visit
Dates of Service	Last MD Visit

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

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18NW2267 R12/22

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 _____

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: