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HOME HEALTH CARE FORM **TENNESSEE/N GEORGIE/N. MISSISSIPPI**

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 844-411-9622

Questions? Call 844-411-9621

Request Type **Date:**	Standard Request: ☐ 48 hours Retro Request: ☐ Retro Requests may take up to 30 days review. If you have received a denied claim – please submit clinical information through appeals.	Urgent Request: ☐ **Please Read if 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: _____

Member Name:	**HHC Name:**
Member ID#: **DOB:**	**NPI#**
Previous Homecare Provider:	**Contact Name:**
Post Hospital Discharge: Yes ☐ **No:** ☐ **Date:**	**BRANCH:**
Start of Care Date: **Auth # (if applicable)**	**Phone:** **Fax:**
Diagnosis: (incl. Codes)	**Ordering MD:**

HOMEBOUND STATUS: Yes ☐ **No:** ☐ **CMS Defined:** Homebound status certified by MD, leaving the home is a considerable and taxing effort, infrequent and short duration or are attributable to receive health care treatment.

What is Being Requested (place dates of service beside each discipline you are requesting).	**# of visits** (incl. for all disciplines requested)	**Frequency of visits** (i.e. 3w2, incl. for all disciplines requested)	**Reason for visits** (please attach current clinical related to reason)
Skilled Nursing (incl wound measurements, name/dosage frequency of medications if appl.)			☐ Wound Care ☐ Foley or PEG care ☐ Access Care (port/PICC) ☐ Teaching/Compliance ☐ Injections/Infusion ☐ Other:
PT (all therapy requests should include current level of functions and goals)			☐ Home Assessment ☐ Exercise/Strengthening ☐ AD/Equipment Training ☐ Energy Conservation ☐ Home Exercise Program ☐ Other ☐ Safety
OT			☐ Strengthening ☐ Safety ☐ Other
ST			☐ Communication ☐ Other ☐ Cognitive ☐ Swallowing
HHA			☐ Assist with ADL's ☐ Functional impairment ☐ Other:
MSW			
Able/willing/teachable caregiver? If no, please explain	**Cigna-HealthSpring CM recommendation?**	**D/C Plan** (discharge planning begins at admission, visits approved may include 2 visits to issue NOMNC):	