THE OHIO STATE UNIVERSITY
HEALTH PLAN

AUTHORIZATION FORM FOR HOME HEALTH OR HOSPICE CARE

Instructions: Please print all requested information and submit this form and required documentation to OSU Health Plan via email at**:** **UtilizationManagement.OSUHealthPlan@osumc.edu** or fax to: **614-292-2667.**
Contact a OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form.

Required documentation: 1. For initial requests, attach SN, PT, OT, ST evaluation(s)
2. Wound assessment(s) may be attached for related wound care requests

PATIENT INFORMATION: PRINT all information requested below:

First Name: _____Last Name: _____ DOB:___/___/_____

Insurance ID #: _____Current Diagnosis: _____ICD-10_____; _____

Current/Previous Auth. #_____

Ordering Physician Name: _____

Anticipated Dates of Service: ____/_____/_____ to ____/_____/_____

Teachable Caregiver: ☐ Yes ☐ No Homebound: ☐ Yes ☐ No; if no, please explain below:

_____

_____

REQUESTED SERVICES: *enter # of visits for all that apply* *****USE/ENTER SAME CODES LISTED IN YOUR CONTRACT AND ON INVOICE TO CORESOURCE***

Service	Number of visits	Service	Number of visits
99601 INFUSION RN VISIT	_____	S 9131 PT VISIT	_____
99600 RN or LPN VISIT	_____	S 9129 OT VISIT	_____
S 9123 RN or LPN VISIT	_____	S 9128 SLP VISIT	_____
S 9127 MSW VISIT	_____	_____	_____

S 9126 HOSPICE CARE IN HOME x ____DAYS

INITIAL MEDICAL NECESSITY/REASON FOR SERVICES: *check all that apply*

☐ Assessment ☐ ADL Training ☐ Labs ☐ Pain Management ☐ PICC Line Care ☐ End of Life Care ☐ IV Meds

☐ Safety Measures ☐ Patient/Caregiver Education ☐ Gait/Transfer Training ☐ Swallowing TX ☐ Speech/Cognitive

☐ Establish HEP ☐ Wound Care/Vac – [2]Note Location(s) and Initial Measurements: _____

IF ADDING TO PREVIOUS AUTH. ADDITIONAL VISITS ARE MEDICALLY NECESSARY DUE TO:

☐ New Order(s) – please attach order/explain: _____

☐ Fall/injuries – please explain: _____

☐ New onset or exacerbation of: _____

☐ Weight-bearing status change from _____ to: _____

☐ [2] Wound status change/update in measurements_____

☐ New DME

☐ New assistive device training

☐ New caregiver

ADDITIONAL COMMENTS TO ABOVE SECTIONS BELOW:

_____

_____

_____

PROVIDER INFORMATION:

Company Name: _____

Telephone Number: (____)_____-_____ext_____ Fax Number: (____)_____-_____

Email Address:_____

Contact Name: _____ Telephone Number: (____)_____-_____ext_____

To be completed by OSU HEALTH PLAN ** ***FOR ABOVE DATES OF SERVICE*****

Services are: ☐ Approved as requested

☐ Partial approval of adjusted number of visits: _____

☐ Denied with reason: _____

Date: _____ Authorization #_____ By_____, RN

Telephone # (614) _____ Additional Comments: _____

_____