The purpose of this form is for a home healthcare prior authorization request. Contact the Blue Advantage (HMO) Medical Management department at 1-866-508-7145 (option 4, option 4) if you have questions.
Please complete all applicable areas below:

### Request for Home Health Authorization Form

#### GENERAL INFORMATION
- [ ] Initial Request
- [ ] Reauthorization Request

#### PATIENT INFORMATION
- Patient’s Name
- Date of Birth
- Is patient homebound?
  - [ ] Yes *(please explain why)*
  - [ ] No
- Diagnosis
- Surgery
  - [ ] Yes *(please list procedure)*
  - [ ] No

#### AGENCY INFORMATION
- Agency Name
- National Provider Identifier (NPI)
- Contact Phone Number
- Contact Fax Number

#### CAREGIVER INFORMATION
- Caregiver Name
- Relationship
- Type of Assistance
  - [ ] Teachable
  - [ ] No
- Primary Phone Number

#### MD INFORMATION
- Ordering MD
- Date of Face-to-Face Visit
- Phone Number
- PCP
- Date of Next MD Visit

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.
16-016_H6453

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**DME/SUPPLIES/IV/LAB**
Vendor Name | Type

**COMMUNITY RESOURCES**

**CURRENT FUNCTIONAL STATUS**

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<tr>
<th>Cognitive</th>
<th>Dress Lower Extremities</th>
<th>Bathing</th>
<th>Toileting</th>
<th>Ambulation</th>
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<td>Alert and Oriented</td>
<td>Requires Assist</td>
<td>Requires Assist</td>
<td>Requires Assist</td>
<td>Requires Assist</td>
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<tr>
<td>Impaired</td>
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<td>Disoriented</td>
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Shaded area for office use only

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<th>Service Request</th>
<th>From</th>
<th>To</th>
<th># Of Visits</th>
<th>Frequency</th>
<th>Auth # Visits</th>
<th>Health Plan Auth #</th>
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<tr>
<td>RN</td>
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<td>HHA Visits</td>
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**MEDICATIONS**

- Med List Attached *(must accompany all initial requests)*

Compliant
- Yes
- No

Teachable Patient/Caregiver
- Yes
- No

Need for Teaching That is Not Being Met

For Reauthorization:
New or Changed Medications

Name of Person Completing Form | Title | Date

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### SKILLED NURSING

**Skilled Nursing:**

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<th>DC Date</th>
<th>Anticipated</th>
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**Clinical Summary**

**Reason for Home Health Aide Services**

**Wound Care Required**

<table>
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<th>Nutritional Status</th>
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Please describe wound(s): i.e., location, type of wound (pressure ulcer with stage/surgical, etc.), measurement (LxWxD, wound edges), appearance (types of tissue in wound bed: eschar, slough, granulation), drainage (color, amount, odor of drainage), evidence of infection

**Patient/Caregiver Education** *(please describe the ability of the patient/caregiver to learn/perform wound care)*

**Care Plan**

**Goals/Plan for this Authorization Period**

**Barriers to Achieve Goals/Plan**

**Interventions**

**Signature**

<table>
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<tr>
<th>Title</th>
<th>Department</th>
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### OTHER SKILLED DISCIPLINES

**PT:**

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**OT:**

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**MSW:**

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</table>

**Reason for Home Health Aide Services**
Home Healthcare Prior Authorization Requirements

Initial Evaluation
- The initial skilled nursing (SN) and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization. However a physician’s order and certification of homebound status is required.
- Speech therapy, occupational therapy and social work require prior authorization for the initial evaluation when ordered after the Start of Care (SOC) date.

Post Evaluation Visits
- Document the initial evaluation results, evidence of homebound status, individualized member goals and plan of care on our Request for Prior Authorization Form. All documentation is expected to be legible or it will be returned and the authorization process cannot move forward. The Request for Prior Authorization Form, OASIS and any supporting clinical documentation must be faxed to the health plan for review within one business day of the evaluation.
- When the faxed clinical documentation is received from home care agency, it will be reviewed using InterQual Home Care criteria. The types of disciplines, number of visits and dates of service will be determined by the health plan using InterQual criteria as a guide.
- When Home Healthcare (HHC) visits have been approved, a faxed approval will be sent to the agency that includes the number of visits for each discipline approved, dates of coverage and the next review date for requests for continued coverage. An approval letter will also be mailed to the member or the member’s legal representative.
- If the clinical documentation does not support the need for HHC services, the case will be sent to the health plan’s medical director for review and determination. If the determination by the medical director is unfavorable, a denial letter will be faxed to the HHC agency. Denial will also be mailed to the member or the member’s legal representative.
Ongoing HHC Visits

- Ongoing request must be submitted on the Blue Advantage Request for Home Health Prior Authorization Form with the following information:
  1. Clearly identify goals that are being met and goals that are not being met for each discipline.
  2. Any progress made toward the unmet goal.
  3. Any barriers identified that will impact the member’s ability to meet the unmet goal.
  4. The plan to address those barriers, including follow up with the member’s attending physician or primary care physician.
  5. Anticipated number of visits needed to meet goals. When any barriers to progress are identified, documentation of physician follow up is required.

- Document the evaluation results, evidence of homebound status, individualized member goals and plan of care on our Request for Prior Authorization Form as listed just above. All documentation is expected to be legible or it will be returned and the authorization process cannot move forward. The Authorization Request Form, additional OASIS documentation, if applicable, and any supporting clinical documentation must be faxed to the health plan for review within two business day of the evaluation.

- When the faxed clinical documentation is received from home care agency, it will be sent for review using InterQual Home Care criteria. The types of disciplines, number of visits and dates of service will be determined by the health plan using InterQual criteria as a guide.

- When HHC visits have been approved, a faxed approval will be sent to the agency that includes the number of visits for each discipline approved, dates of coverage and the next review date for requests for continued coverage. An approval letter will also be mailed to the member or the member’s legal representative.

- If the clinical documentation does not support HHC services, the case will be sent to the health plan’s Medical Director for review and determination. If the determination by the medical director is unfavorable, a Notice of Medicare Non-Coverage (NOMNC) will be faxed to the HHC agency and mailed to the member or the member’s legal representative.

  **Note:** To prevent a gap in coverage all suggested ongoing visits must be submitted at least **two business days prior to the coverage period end date** (or before the last visit, whichever is sooner).

  A documented face–to–face visit with your attending physician (primary care physician or specialist treating your condition) must take place within 30 days of start of care or within 60 days of any request for recertification of HHC visits.

Discharge Summary

- When members are being discharged from services, the agency will need to submit a discharge summary or form **two business days prior to the coverage period end date (or last visit, whichever is sooner)** that includes the number of visits provided, date of last visit and the disposition for each discipline. Also include a copy of the signed Notice of Medicare Non-Coverage that was delivered to the member.

Incomplete/Lack of Information

- If the Authorization Form is not filled out in its entirety, including defined medical goals and plan of care, it will be rejected as an incomplete request and the authorization request process will not move forward.

- Blue Advantage must receive clinical documentation in a timely manner, generally no later than noon the next business day following the request for authorization. However, in rare circumstances you may be asked to provide information in a shorter timeframe.