

# Home Health Care Pre-Authorization Request Form - Commercial

Member Name:	Member ID #:
	Member DOB:
Requesting Agency:	Contact Name:
Requesting Provider ID #:	Contact Phone # and Ext:
Tax ID #:	Contact Fax #:
Previous Authorization #, if applicable:	Fax # Where Decision Should Be Faxed To:
ICD-9*/ICD-10* Code(s):	Referring Physician:

\* Services or inpatient discharges prior to Oct. 1, 2015 must use ICD-9 codes; services or inpatient discharges after Oct. 1, 2015 must use ICD-10 codes.

**Fax Form with Supporting Medical Documentation to Clinical Review at 1-866-934-5313 or 1-860-409-2437**

**Traditional home care** or  **Hospice care** (signed Hospice Election Form is required at the start of care)

- Number of visits used to date: \_\_\_\_\_
- Notification of discharge from home health services: Date \_\_\_\_\_ Discharge reason \_\_\_\_\_
- Date span for requested services \_\_\_\_\_ to \_\_\_\_\_

Traditional Home Care		Completed by CCI	
<input type="checkbox"/> Skilled Nursing Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> PT Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> OT Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> ST Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> MSW Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> Other _____	# Requested:	# Approved:	Approved by:
Hospice Care		Completed by CCI	
<input type="checkbox"/> Skilled Nursing Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> PT Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> OT Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> ST Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> MSW Visits	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> Home Health Aide	# Requested:	# Approved:	Approved by:
<input type="checkbox"/> Per diem (rev code 0651) <i>If included in your ConnectiCare contract</i>	# Requested:	# Approved:	Approved by:

- Member receiving wound care and needs authorization for supplies. Vendor: \_\_\_\_\_
- Total # of authorized visits requested to date \_\_\_\_\_ out of \_\_\_\_\_ per member's benefit (completed by CCI)

**Fax form and medical documentation to Clinical Review at 1-866-934-5313 or 1-860-409-2437**

**Please Note:**  
**Services are not considered authorized until ConnectiCare issues an authorization.**  
**Lack of information will delay processing of request.**