PRIOR AUTHORIZATION for HOME HEALTH and HOSPICE

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Date Requested:	Ordering Physician:
Home Health Agency:	Home Health Agency Address:
Home Health Agency Provider NPI#:	Home Health Agency Tax ID#:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST / CLINICAL INFORMATION

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent	**Start of Care:**	**Requested Date (s) of Service:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**	
Recent Acute Care Hospital Stay: ☐ Yes ☐ No	**Facility:**	**Inpatient Length of Stay:**
Recent Rehab/Skilled Nursing Facility Stay: ☐ Yes ☐ No	**Facility:**	**Rehab/SNF Length of Stay:**
Date of Injury/Surgery:	**Description of Injury/Surgery:**	

Home environment/living arrangement:

Single or multi-level home: ___________________________ # of steps to enter the home: __________________ # of steps within the home: __________________

Does the patient live alone? ☐ Yes ☐ No Is the patient homebound? ☐ Yes ☐ No If "*yes*", why: ____

A. Request for Home Health Service (s): ** Policy year and/or lifetime limits may apply.*

Service: _______________________________ CPT/HCPCS: ___________________ # of visits approved: ______# of visits used: ______ # of visits requested: ______

Service: _______________________________ CPT/HCPCS: ___________________ # of visits approved: ______# of visits used: ______ # of visits requested: ______

Service: _______________________________ CPT/HCPCS: ___________________ # of visits approved: ______# of visits used: ______ # of visits requested: ______

Service: _______________________________ CPT/HCPCS: ___________________ # of visits approved: ______# of visits used: ______ # of visits requested: ______

B. Request for Intravenous/Medication Therapy: **Some medications are pre-authorized through PEHP pharmacy department.*

Place of service for infusion: *Please check.* ☐ Home ☐ Ambulatory Infusion Center/Clinic ("AIC")

Description: ____ CPT/HCPCS: _______________________________ Frequency: ________________________

Description: ____ CPT/HCPCS: _______________________________ Frequency: ________________________

Description: ____ CPT/HCPCS: _______________________________ Frequency: ________________________

Description: ____ CPT/HCPCS: _______________________________ Frequency: ________________________

C. Request for Wound Care:

Wound Care Orders: ____ Frequency: ______________________

Wound # _______ Location: ___________________ ☐ Left ☐ Right Measurements: ________________________________ Wound VAC (NPWT)? ☐ Yes ☐ No

Wound # _______ Location: ___________________ ☐ Left ☐ Right Measurements: ________________________________ Wound VAC (NPWT)? ☐ Yes ☐ No

D. Indication for Skilled Nursing Needs: *Please check.*

☐ Enteral Therapy ☐ Hospice ☐ Venipuncture ☐ IV Therapy ☐ IV Line Care (*please check*): ☐ Central Venous Catheter ☐ PICC Line ☐ Implanted Port

☐ Other (*please specify*): ____

Additional Comments:

Please fax completed form and medical records to 1-801-366-7449.