Neighborhood Health Plan OF RHODE ISLAND™

Home Care Services
Prior Authorization Form
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☐ **New Request** ☐ **Re-Certification Request -Auth #** _____

Please return completed form to the Utilization Management Department at (401)459-6023.
Please refer to Neighborhood's Clinical Medical Policies which are available on our web site, www.nhpri.org for more detailed information about these benefits, authorization requirements, and coverage criteria.

Member's Name:	Member's ID #:	Member's DOB:
Agency's Name:	Agency's NPI #:	Date of Request:
Agency's Phone#:	Agency's Fax#:	Agency's Contact Name:
Agency's Location:	Ordering MD/Phone *(if applicable)*:	

PLEASE CHOOSE SERVICE:
Section A☐ RN Initial Assessment and/or ☐Home Health Care Services and/or ☐ T1001-Regulatory Assessment Req.(not initial assessment)
Section B☐ Unity/Integrity Combo-Homemaker (complete Section B)
Section C☐ HHA/CNA Long Term Care Hours (complete Section C) and/or
Section D☐ RN/LPN Private Duty Hours (complete Section D)

SECTION A: Please Submit Plan of Care

If T1001-Regulatory Assessment Requirement ☐ (Fill in Grid on Right only)

Medical History:_____
_____

Check One: ☐More Visits ☐Date Extension Reason:_____

Additional Caregiver Available? ☐Family/Friend ☐Other Agency ☐ None

Is Caregiver/Member: ☐ Willing/Able ☐ Unwilling/Unable to provide care

Knowledge/skills: _____

Early Intervention Program: ☐ Yes - Date of Evaluation_____ ☐ No

Resources/Support: _____

Home Exercise Program: ☐ Learning ☐ Independent ☐ Not Progressing

Medical/Social Day Care:_____

Treatment Related to: ☐ Workers Compensation ☐ Motor Vehicle Accident
☐ Other _____

VISITS USED TO DATE*(required)*:_____

Type of Service Requested: RN/LPN HHA/CNA PT/OT/ST/ MSW	**HCPCS/ CPT Codes**	**Units**	**Start Date**	**End Date**

Diagnosis Description	**Codes**

SECTION B: Please submit Skilled Nurse Assessment and Plan of Care

☐ **S5125 Combo Services**: Personal care and homemaking services performed by a HHA/CNA during the same session *(per 15 min)*
Diagnosis Codes_____
Number of hours/week _____ **Units/week** _____
Start Date_____ **End Date**_____
Total number of units for this request_____

☐ **S5130 Homemaker Services**:

Diagnosis Codes_____
Number of hours/week _____ **Units/week** _____
Start Date_____ **End Date**_____
Total number of units for this request_____

Section C: Please submit initial Skilled Nurse Assessment and Plan of Care	
Diagnosis Codes_____ **HCPCS/CPT of Service Requested** _____ **Number of hours/week** _____ **Units/week** _____ **Start date**_____ **End Date**_____ **Total number of units for this request**_____	**Additional codes if needed:** **HCPCS/CPT of Service Requested** _____ **Number of hours/week** _____ **Units/week** _____ **Start date**_____ **End Date**_____ **Total number of units for this request**_____

Section D: Please submit recent Skilled Nurse Assessment and Plan of Care	
Diagnosis Codes_____ **HCPCS/CPT of Service Requested** _____ **Number of hours/week** _____ **Units/week** _____ **Start date**_____ **End Date**_____ **Total number of units for this request**_____	**Additional codes if needed:** **HCPCS/CPT of Service Requested** _____ **Number of hours/week** _____ **Units/week** _____ **Start date**_____ **End Date**_____ **Total number of units for this request**_____

Brief Summary of Care:

Respiratory /Cardiac Status	Ventilator/Trach Care	☐ < 12 hrs/day ☐ > 12 hrs/day
	Oxygen Therapy ☐CPAP ☐ BiPAP	☐ Yes ☐ No
	Aspiration/Reflux precautions	☐ Yes ☐No
	Suctioning	☐ Yes ☐ No
	Apnea monitor/pulse ox	☐Yes ☐ No
Nutrition	Tube Feeding/G-Tube Care	☐Yes ☐ No
	Difficulty/prolonged oral feeds	☐Yes ☐ No
Neurological	Cognitively Impaired (age > 19 yrs.)	☐Yes ☐ No
Medications/IV's	Daily Meds (q8/hr or less)	☐Yes ☐ No
Elimination/Skin Care	Catheterization	☐Yes ☐ No
	Ostomy Care	☐Yes ☐ No
	Decubitus/Wound Care	☐Yes ☐ No

ATTENTION: Please complete all fields on the form and submit all clinical documents. Documentation may include MD orders, physician office notes, consults and all other evaluations, results of diagnostic testing, previous treatment outcomes, and patient's clinical information. This will help us process your request without delay. Failure to provide sufficient information will delay your request as it will be returned.

Late or Retroactive Authorizations: Authorizations are to be obtained prior to the date of service or admission. However, authorizations for unscheduled, emergent services that cannot be requested in advance or during normal business hours, can be retroactively requested up to three business days after the date the service is rendered or the date of admission (i.e. by the end of the third business day following). Any service requested greater than three business days after the date the service is rendered will not be considered.

Requests submitted without clinical information cannot be processed as they are incomplete.

NOTE: THIS FORM MUST BE SIGNED BY PROVIDER (RN, MD, Administrator/Equivalent, where applicable)
PER EOHHS, Neighborhood cannot pay for services provided by individuals legally responsible for the member. *I attest that contracted services provided to this member will not be rendered by a person that is legally responsible for the member.*

Signature and Title of Treating Provider:	**Date:**

Authorization is not a guarantee of payment.

Authorization #:	**Date of Service:**	**Services Approved:**
UM Initials:	**Notification Date:**	☐ **Not Approved –letter to follow**