Magellan COMPLETE CARE®

UM Home Health Authorization Form

Overview	Agency Information
Start of care date: ____/____/_____ Initial: _____ Reauthorization date: ____/____/_____ Agency D/C date: ____/____/_____ Anticipated: □ Actual: □ M.D. agrees: Y / N Patient agrees: Y /N	Agency name: _____ Agency/Provider NPI: _____ Contact name: _____ Phone: (__)_____ Fax: (__)_____
Patient Information	**Primary Care Provider Information**
Name: _____ S.O.C. Address: _____ City:_____ State: _____ ZIP:_____ D.O.B.: ___/____/_____ Phone: (___)_____ Patient insurance plan ID #: _____ Homebound: Y/N Why? _____ Diagnosis: _____ Surgery: _____	Ordering MD/PCP: _____ Ordering MD/PCP NPI: _____ Medical office: _____ Phone: (__)_____ Fax: (__)_____ Date of next scheduled visit: _____/_____/_____
	Health Plan Information
	Health plan name: _____ Health plan CM: _____ Initial auth. #: _____ Phone: (__)_____ Fax: (__)_____

Patient Prognosis			
☐ Excellent	☐ Good	☐ Very good	☐ Fair
☐ Guarded	☐ Poor	☐ <6 months to live	☐ Terminal

Current Functional Status

Cognitive	Dress Lower Extremities	Bathing	Toileting	Ambulation
☐ Alert/oriented	☐ Independent	☐ Independent	☐ Independent	☐ Independent
☐ Impaired	☐ Requires assist.	☐ Requires assist.	☐ Requires assist.	☐ Requires assist.
☐ Disoriented	☐ Unable	☐ Unable	☐ Unable	☐ Unable

Service Request	From	To	# of Visits	Frequency	Auth. # Visits	Health Plan Auth. #
RN/LPN						
HHA						
PT						
OT						
ST						
MSW						
Other						

Communication
Comments: **Name: _____ Title: _____ Date: ____/____/_____**

Skilled Nursing
Discharge date: ____/____/_____ Anticipated: ☐ Actual: ☐
Clinical summary:
Medications: Compliant Y / N Teachable patient: Y / N Medicines list attached: Y / NA
Goals/Plan for this authorization period: **Barriers to achieve goals/plan:** **Interventions:**

Signature:	Title:	Department:	Date:

Other Skilled Disciplines
Discharge date: ____/____/_____ Anticipated: ☐ Actual: ☐
Please complete a separate page when more than one skilled discipline is providing care.
Clinical summary: **☐ PT ☐ OT ☐ ST ☐ MSW ☐ OTHER_____**
Reason for home health aide services:
Clinical summary:
Goals/Plan for this authorization period: **Barriers to achieve goals/plan:** **Interventions:**

Signature:	Title:	Department:	Date: