PASSPORT HEALTH PLAN

HOME HEALTH AUTHORIZATION FORM

Date: _____ Auth #: _____ 19.6.2

Fax to: **502-585-8204** PHP R.N. Initials: _____

Attn: **PHP Home Health**

MEMBER INFORMATION

AUTHORIZATION NUMBER _____

MEMBER'S NAME _____

PASSPORT ID _____ MEMBER'S DOB _____

PROVIDER INFORMATION

ORDERING MD _____

PROVDER ID _____ PROVIDER CONTACT _____

REQUESTING PROVIDER _____

PROVIDER PHONE _____ PROVIDER FAX _____

CLINICAL INFORMATION

INITIAL REQUEST? ☐ YES ☐ NO IF NO: NUMBER OF VISITS TO DATE _____ DATE OF LAST VISIT _____

DIAGNOSIS _____

DIAGNOSIS ICD 9 CODE _____

DISCIPLINE AND NUMBER OF VISITS FOR EACH:

Discipline	RN	HH	PT	OT	ST	SW	RD
# visits							

DATES OF SERVICE: FROM _____ TO _____

CLINICAL SUMMARY: (INCLUDE WOUND MEASUREMENTS AND LABS IF APPLICABLE)

_____

_____

_____

WHY ARE VISITS REQUIRED?

_____

_____

_____