

HOME HEALTH AUTHORIZATION FORM

PAD FAX: 888-367-7480 PAD PHONE 844-865-7864

Date: _____ Auth #: _____

Fax to: **888-367-7480**

ROUTINE REQUEST URGENT / EXPEDITED REQUEST

URGENT / EXPEDITED- if waiting under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. **For Urgent / Expedited requests you may call: 844-865-7864**

MEMBER INFORMATION

MEMBER'S NAME _____

PAD ID _____ MEMBER'S DOB _____

PROVIDER INFORMATION

ORDERING MD _____

PROVIDER 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?

Passport Advantage | 5100 Commerce Crossings Drive | Louisville, KY 40229

Prior authorization is required to verify whether the services are medically necessary. Approval for specific services does not indicate or imply the service is a covered benefit. Coverage is determined by the member's benefit plan, the provider or facility's eligibility for payment, claim processing requirements, and the provider or facility's participation agreement with Passport Advantage.