

DATE: _____

FAX TO: 502-585-8204

ATTN: PASSPORT ADVANTAGE HOME HEALTH

Initial Ongoing



HOME HEALTH AUTHORIZATION FORM

Member's Name _____

DOB _____

Passport Advantage ID or SSN _____

Authorization Number _____

Primary Diagnosis Code _____

Secondary Diagnosis Code _____

Ordering MD (First Name Also) _____

Discipline(s) Frequency of Visits _____

2nd Discipline(s) Frequency (If Applies) _____

Date of Episode of Care _____

Why is Member Homebound _____

Skilled Services Needed _____

Clinical Information to Support Skilled Need

Provider ID _____

Contact Person _____

Requesting Agency _____

Agency Phone # _____

Fax # _____

Authorized By _____