THE OHIO STATE UNIVERSITY
HEALTH PLAN

AUTHORIZATION FORM FOR HOME HEALTH OR HOSPICE CARE

Instructions: Please print all requested information and submit this form and required documentation to OSU Health Plan via email at**:** **UtilizationManagement.OSUHealthPlan@osumc.edu** or fax to: **614-292-2667.**
Contact a OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form. *Up to 2 skilled nursing visits will be approved retroactively with in-network providers for urgent home health care needs on weekends or holidays.*

Required documentation: 1. For initial requests, attach SN, PT, OT, ST evaluation(s)
2. Wound assessment(s) may be attached for related wound care requests

PATIENT INFORMATION: PRINT all information requested below:

First Name: ___________________________Last Name: _______________________________ DOB:___/___/_____

Insurance ID #: __________________Current Diagnosis: ____________________ICD-10___________; ___________

Current/Previous Auth. #____________________

Ordering Physician Name: ____

Anticipated Dates of Service: ____/_____/_______ to ____/_____/_______

Teachable Caregiver: ☐Yes ☐No Homebound: ☐Yes ☐ No; if no, please explain below:

____

____

REQUESTED SERVICES: *enter # of visits for all that apply* *****USE/ENTER SAME CODES LISTED IN YOUR CONTRACT AND ON INVOICE TO CORESOURCE***

Service	Number of visits	Service	Number of visits
99601 INFUSION RN VISIT	_____	S 9131 PT VISIT	______
99600 RN or LPN VISIT	_____	S 9129 OT VISIT	______
S 9123 RN or LPN VISIT	_____	S 9128 SLP VISIT	______
S 9127 MSW VISIT	_____	_______________	______

S 9126 HOSPICE CARE IN HOME x ____DAYS

INITIAL MEDICAL NECESSITY/REASON FOR SERVICES: *check all that apply*

___Assessment ___ ADL Training ___ Labs ___ Pain Management ___ PICC Line Care ___ End of Life Care

___ IV Meds ___ Safety Measures ___ Patient/Caregiver Education ___ Gait/Transfer Training ___ Swallowing TX

___ Speech/Cognitive ___ Establish HEP ___ Wound Care/Vac – [2]Note Location(s) and Initial Measurements below:

____

IF ADDING TO PREVIOUS AUTH. ADDITIONAL VISITS ARE MEDICALLY NECESSARY DUE TO:

☐ New Order(s) – please attach order/explain: ____

☐ Fall/injuries – please explain: ____

☐ New onset or exacerbation of: ____

☐ Weight-bearing status change from _____________ to: ________________

☐ [2] Wound status change/update in measurements____

☐ New DME

☐ New assistive device training

☐ New caregiver

ADDITIONAL COMMENTS TO ABOVE SECTIONS BELOW:

____

____

PROVIDER INFORMATION:

Company Name: ____

Telephone Number: (____)_____-______ext_____ Fax Number: (____)_____-_______

Email Address:____

Contact Name: ____ Telephone Number: (____)_____-______ext_____

To be completed by OSU HEALTH PLAN ** ***FOR ABOVE DATES OF SERVICE*****

Services are: _____Approved as requested

_____Partial approval of adjusted number of visits: ____

_____Denied with reason: ____

Date: _____________ Authorization #____________________ By____________________________________, RN

Telephone # (614) _______________________ Additional Comments: _____________________________________

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This Authorization is for medical necessity only. It is not a guarantee of payment. Approval of benefits is subject to premium payments and coverage limitations, including waiting periods where applicable.