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 an OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance completing the entire form.

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_____/_____/_____

REQUESTED SERVICES: ***USE/ENTER SAME CODES LISTED IN YOUR CONTRACT AND ON INVOICE TO TRUSTMARK.** *Enter # of visits requested for all that apply.*
Up to two home nursing visits and one physical therapy visit will be retroactively approved for urgent home care needs outside OSU Health Plan office hours, such as on weekends and holidays. Additional visits must meet medical necessity criteria for coverage.

Service	Description	Number of Visits	Service	Description	Number of Visits
99600	Unlisted home visit	_____	Q5001	Home hospice (per diem)	_____
99601	Home infusion (up to 2 hrs.)	_____	S9123	RN home visit	_____
99602	Home infusion (each additional hr.)	_____	S9124	LPN home visit	_____
G0151	PT home visit	_____	S9126	Home hospice (per diem)	_____
G0152	OT home visit	_____	S9127	MSW home visit	_____
G0153	ST home visit	_____	S9128	ST home visit	_____
G0155	MSW home visit	_____	S9129	OT home visit	_____
G0299	RN home visit	_____	S9131	PT home visit	_____
G0300	LPN home visit	_____	_____	_____	_____

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*****

Patient Name: _____

Services are: □ Approved as requested □ Partial approval of adjusted # of visits _____
□ Denied with reason:_____

Date: _____Authorization #_____By_____, RN

Telephone # (614)_____Email Address: _____

Additional Comments: _____

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