Capital

Home Health Skilled Nursing and/or Therapy Visit Treatment Form

Fax completed form to: 717.540.2171

To ensure accurate and timely processing of your request, please complete all fields on the form.

SECTION I—Member Information				
Member Name:		Member ID:		Date of Birth:
Plan Type:	☐ Traditional	☐ Medicare Advantage PPO	☐ PPO	☐ Comprehensive
	☐ Medicare Advantage HMO	☐ POS	☐ Keystone Health Plan® Central, Inc.	
Does member have other primary insurance? ☐ N/A ☐ Workers' Comp ☐ Auto ☐ Other:				

SECTION II—Authorization
Authorization Type: ☐ Initial Authorization ☐ Reauthorization (Subsequent) ☐ Prior Authorization #:
Level of Urgency: ☐ **Standard** Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature. ☐ **Expedited** Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations: • Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or • In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.
For Expedited Request, Please Explain:

Admission Date:	End Date:	Requested Units/Days:
Primary Diagnosis:	Additional Diagnosis:	
Is care provided a result of an MVA or work-related injury? ☐ Yes ☐ No If yes, please indicate which:		
All Procedure/HCPC Code(s):		
Place of Service: ☐ Assisted Living Facility ☐ Home ☐ Other (specify):		

SECTION III—Servicing/Performing Provider Information	
Servicing Provider Name:	Servicing Provider NPI:
If Service/Procedure is being done in a Facility, name of Facility:	Facility NPI (if known):
☐ Local Blue Plan (if yes, please provide Local Blue Plan identification)	
Servicing Address:	

Servicing City:	Servicing State:	Servicing ZIP Code:
Contact Name:	Contact Phone:	Fax:

SECTION IV—Referring Provider Information (if different than above)	
Referring Provider Name:	Requesting Provider NPI:
Referring Address:	

Referring City:	Referring State:	Referring ZIP Code:
Contact Name:	Contact Phone:	Fax:

SECTION V—Additional Information Required	
☐ Fax along with this cover sheet the initial evaluation or progress notes, and any additional Clinical documentation related to this request.	
Number of Skilled Nursing Visits requested: Dates of service requested:	Number of Occupational Therapy Visits requested: Dates of service requested:
Number of Physical Medicine Visits requested: Dates of service requested:	Number of Medical Social Worker Visits requested: Dates of service requested:
Is this service in lieu of Hospital Care? ☐ Yes ☐ No	Is this request for continuation of services: ☐ Yes ☐ No
Is the member homebound? ☐ Yes ☐ No	Is Caregiver available to be taught care? ☐ Yes ☐ No
Member's mental status:	Member's activity level:
If Caregiver is unable to be taught, please list alternative plan of care:	

SECTION VI—Wound Information	
Width:	Length:
Depth:	Location:
Drainage Description:	Tissue Appearance:
Please indicate the last time the wound was seen by a physician and/or wound care nurse:	
Please indicate the dressing/treatment type:	
Discharge Goals and Anticipated Date of Discharge:	

SECTION VII—Home Health Therapy Services			
Physical Medicine: ☐ Yes ☐ No		Occupational Therapy: ☐ Yes ☐ No	
Start of Care Date:		Ambulation with Assistive Device (if yes, what type): ☐ Yes ☐ No	
Strength:	Balance:	Endurance:	ROM:
Coordination/Motor Function:			
Why does this person have difficulties in his/her daily activities/occupation? What adaptation is being made to make it possible for him/her to manage better to impact his/her health and well-being:			
GOAL: What is the plan to improve, restore, or compensate for lost function? Is it appropriate for in-home care?			
Goals/Interventions/Outcome and Anticipated Discharge Date:			

SECTION VIII—Physician Signature	
Please Sign:	Date:

(Preauthorization is not a guarantee of payment.)