UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

S.OC. Date: ___/___/___ Initial: □ Reauthorization:___/___/___
Agency D/C Date:___/___/___: Anticipated □ Actual □ MD Agrees: Y/N Patient Agrees: Y/N

Patient Information
Name:_____
S.O.C. Address:_____
_____
Telephone #:_____
DOB:___/___/___
Homebound: Y/N Why?_____
Diagnosis:_____
Surgery: N/A_____
Patient Prognosis:
Poor / Guarded / Fair / Good / Very Good /
Excellent / <6 months to live / Terminal.
MD Information
Ordering MD:_____
MD Phone#:_____
PCP:_____
Date of Next MD Visit:___/___/___
Health Plan Information
Health Plan Name:_____
Insurance #:_____
Health Plan CM:_____
Initial Auth#:_____
Telephone #:_____Fax #:_____

Agency Information
Agency Name:_____
Provider Number:_____
Contact:_____
Telephone #:_____Fax#:_____
DME/Supplies/IV/Lab
Vendor Name:_____
Community Resources_____
_____
Caregiver Information
Name:_____
Relationship:_____
Type of Assistance:_____
Teachable/Not Teachable:_____
Primary Phone#:_____

Maternity Care N/A □
Delivery Date___/___/___Time Of Delivery__:__
Discharge Date___/___/___Time of Discharge__:__

Current Functional Status

Cognitive	Dress Lower Extremities	Bathing	Toileting	Ambulation
□Alert/Oriented	□ Independent	□ Independent	□ Independent	□ Independent
□ Impaired	□ Requires assist	□ Requires assist	□ Requires assist	□ Requires assist
□ Disoriented	□ Unable	□ Unable	□ Unable	□ Unable

Service Request	From	To	# Of Visits	Frequency	Auth # Visits	Health Plan Auth #
RN						
HHA/Hrs&Visits						
PT						
OT						
ST						
MSW						
Other						

Communication

Comments:_____
_____
_____
_____
_____
Name:_____**Title:**_____**Date:** ___/___/___

SKILLED NURSING D/C Date:___/___/___ Anticipated □ Actual □
Clinical summary:

Reason for Home Health Aide Services:

Wound Care N/A□	**Wound 1**	**Wound 2**	**Wound 3**
Location			
Appearance			
Measurement			
Drainage			
TX and Frequency			

Medications: Compliant: Y/N Teachable Patient: Y/N Med List Attached: NA/Y
Goals/Plan for this Authorization Period:

Barriers to Achieve Goals/Plan:

Interventions:

Signature: Title: Department: Date: / /

OTHER SKILLED DISCIPLINES D/C Date: **/ /** Anticipated □ Actual □
Please complete a separate pg. 2 when more than one skilled discipline providing care
PT OT ST MSW Other
Reason for Home Health Aide Services:

Clinical summary?

Goals/Plan for this authorization period:

Barriers to achieve goals/plan:

Interventions:

Signature: Title: Department: Date: / /

Universal Health Plan/Home Health Authorization Form (UHHA)

Revised Guidelines for Use Effective 2/13/07

The purpose of this form is to streamline the authorization process and standardize all the information needed in one easy-to-use format. **This two-page form will be faxed, called, or sent electronically to participating Health Plans**, according to the Health Plan's protocol. If the form has been faxed then the first page will be faxed back by the Health Plan to the Home Health Agency with authorization or via another method according to the Health Plan's protocol.

No line is optional; there is a reason for every line. Indicate N/A if the question does not apply.

Be sure to write legibly.

- S.O.C. (start of care), this is the date the Home Health Agency admits the patient. This date must be filled in with every request submitted.
  Initial: check this box when the authorization is the initial authorization request.
  Reauthorization: write in the date of the reauthorization request. This date must be sequential to the previous authorization request or reflect the date services resumed after an inpatient admission, if the member was not discharged from the Home Health Agency when admitted inpatient.
- Agency Discharge: This date reflects the date the member is discharged from the Home Health Agency. The date of the **LAST** skilled discipline visit needs to be on this line. Home Health Agency must submit this info to the Health Plan at time of discharge. This may be accomplished by faxing the first page of the UHHA form to the Health Plan upon discharge, with the discharge date clearly indicated. No other clinical information is necessary at that time.
- Discharge Agreement: Regulations require documentation that MD and Patient are in agreement with the discharge. Indicate by circling Y for yes and N for no. If no, provide details on page 2 of the UHHA form and fax both pages to the insurer.

Patient information:

- This section must be filled out completely. Home Health Agency should write in the Start of Care address, as this address does not always correspond with the member's permanent address in the Health Plan's database.
- Homebound: This must always be completed with "reason why" specified. This reason is not the diagnosis.
- Diagnosis: Primary diagnosis and related secondary diagnosis associated with the reason for the home health care admission.
- Surgery: Complete if applicable. Include the procedure and date of surgery.

Patient Prognosis:

- Circle the appropriate prognosis for the patient

MD Information:

- The ordering MD and the PCP may be different. Be sure to indicate who is ordering the home care services along with the PCP.
- Next MD visits date to be completed by Home Health Agency. This needs to be updated on subsequent authorization requests as applicable. Please add details regarding which MD the patient will be seeing

Health Plan Information:

- This information identifies the Health Plan, patient's insurance number, the Health Plan's Case Manager if applicable, the initial authorization number, if applicable, and contact numbers.

Agency Information:

- This information identifies the Home Health Agency name, specific insurance provider number, contact person and numbers. Ensure the fax number is the number where the authorization approval/denial will be faxed to.

DME/Supplies/IV/Lab:

- Indicate the supplier of the DME equipment, wound care supplies, IV equipment and/or in home lab vendor. Additional details can be provided on page 2 as necessary.

Community Resources:

- Indicate the community agency involved and services provided. (Including but not limited to MOW, Homemaking, etc). Additional details can be provided on page 2 as necessary.

Caregiver Information:

- Indicate the person that is responsible for providing assistance to the patient in the home. This person may be the patient, family member or friend.
- Additional information related to the caregiver's ability to provide care and the type of care as well as if they are teachable or not is requested in this area.

Maternity Care:

- Complete this section in its entirety when appropriate. Use military time. Check the N/A box if not appropriate.

Current Functional Status:

- This section provides valuable data as to the Patient's status regarding ADLs & IADLs at the time of admission to Homecare.
- Check the box in each of the 5 categories that best describes the skilled assessment of the patient.
- Whenever submitting a subsequent reauthorization request, please update the patient's status.

Service Request/Approval:

- All the disciplines providing care utilize this section for request of services.
- Service request is the left part of the section. The Home Health Agency fills in the "From and To" dates requested for authorization. Because not all disciplines always start on the same day; therefore the "From" dates may be different. The "To" dates however need to be the same for all disciplines. If the Home Care Agency does not adjust this for multiple disciplines, the Health Plan will.

- The number of visits requested for that time frame is indicated next. NO ranges will be accepted.
- Frequency must reflect the projected visit schedule. NO ranges will be accepted
- Home Health Aide section must indicate hours provided and visit frequency.
- Approval section is completed by the Health Plan, authorizing the number of visits, which is determined by supportive clinical data, the authorization number.
- Other section is for those disciplines not previously addressed, i.e.: nutrition or others based upon arrangements with the specific Health Plan

Return Communication:

- This section is to be used by the Health Plans to communicate back to the Home Health Agency. If additional details are needed prior to making a decision, the request from the Health Plan may be in this area.
- The Health Plan designee provides a signature, title and date.
- The Universal Health Plan/Home Health Authorization form authorization will be communicated back to the Home Health Agency per the Health Plans protocol.

The top of page two begins with the Patients name and the Home Health Agency. Please ensure this data is provided because the pages often become separated.

Skilled Nursing:

- Anticipated discharge date is the projected time in which goals should be met.
- Clinical Summary: needs to be diagnosis appropriate and concise.
- Clearly define the clinical information that supports the need for skilled nursing visits. Do not just list the patient's diagnosis. Refer to Medicare Skilled Home Health Care Criteria as appropriate.
- If applicable, refer to the Home Care Agency/Health Plan Disease State/Catastrophic program for specific documentation and clinical data needed for ongoing progress along the clinical pathway.
- Include data such as vital signs, Lung sounds, blood sugars, weights, pertinent lab results, as appropriate
- Add details regarding medication dose adjustments, response to teaching, response to medications

Reason For Home Health Aide Services:

- The skilled discipline supervising the home health aid (HHA) completes this section, supporting the need for the HHA.

Wound Care:

- Check N/A box if this is not appropriate.
- Must be completed on all patients that have wounds. Details must be updated with each reauthorization request.
- Location of the wound must be specific.
- Appearance should include description of wound, color of wound bed, wound edges, edema, erythema or visible structures (bone, muscle).
- Measurements include length, width and depth of wound in mm/cm
- Drainage description of color, odor amount and consistency.
- TX and frequency are the wound care orders. Provide details regarding what the ordered treatment is and how frequently it is ordered.

Medication: Indicate the appropriate response for the patient regarding medication management (compliance & teachability). Certain Home Health Agency/Health Plan Disease State/Catastrophic programs require medications to be listed. Please indicate N/A; Yes if attached, and No as appropriate.

Goals/Plan for this Authorization Period*:* Data should include specific short term & long term goals that are patient specific. Also, the nursing education plan specific for the patient to reach the goals for **THIS** authorization period needs to be listed. This section needs to be updated with each authorization request.

Barriers to Achieve Goals/Plan: This section needs to contain identified obstacles that may impede progression towards meeting the goals/plan. However, the goals & plan need to also address these barriers. Home Health Agencies and the Health Plans can collaboratively address these concerns. These need to be modified with each authorization request as appropriate.

Interventions: This area should include the specific nursing/therapy interventions that support the goals/plan for the specific authorization request. These need to be modified with each authorization request.

Other Skilled Disciplines: This section should be completed by the other skilled disciplines involved in patient care. Use an additional page 2 when more than one Therapy is providing care. Check the appropriate corresponding discipline and complete all sections as described above. See above details under "Skilled Nursing Goals/Plan for this Authorization Period", "Barriers to Achieve Goals/Plans", and "Interventions" sections for details needed on each authorization request.

Signature*:* Signatures are required for all requests. Note the signature area after the Skilled Nursing section and/or the Other Skilled Disciplines section of the authorization form. The date should be reflective of the date the information was obtained, not the date the form was filled out.