



Home Care Rehabilitation Authorization

Circle: PT OT ST SS HHA

Circle: Univera Healthcare Univera PPO SeniorChoice Medicare PPO PlusMed Child Health Plus Family Health Plus Other: _____

Member Name: _____ SOC: _____ Authorization #: _____ Insurance I.D. #: _____ Primary Dx: _____

DOB: _____ Secondary Dx or previous related Dx: _____

Homebound Due To: _____ M.D. ordering: _____

Family/ CG availability: _____ Psycho-social Issues: _____

Home Care Agency: _____ Therapist: _____ Evaluation Date: _____ Prior Level of Function: _____

Ambulation: How far (in feet)? _____ WB status: _____

Assistive Devices: _____ Assist: _____

Balance: Good Fair Poor

Stairs: # steps: _____ Device _____ Level of Assist: _____

Circle below:

Transfers: Independent Min. Assist Mod. Assist Max. Assist Dependent

ADL: Independent Min. Assist Mod Assist Max Assist

HHA Frequency/ duration requesting: _____

Strength/ Deficits (note- MM, grade): _____

ROM limits: (note joint/motion/measurement): _____

Language / Communication: _____ Dysphagia: _____

TOTAL # OF HOME VISITS COMPLETED TO DATE: _____

TOTAL # OF VISITS REQUESTING: _____ FROM ____/____/____ THRU ____/____/____

Short Term Goals: _____

(BELOW FOR UNIVERA HEALTHCARE USE ONLY)

Date: _____ Authorization received from: _____

Visits by: P.T. O.T. S.T. MSW HHA From _____ Thru _____ Authorization #: _____ Total visits authorized: _____