

Home Care Authorization Form

Service (circle):	RN	MSW	HHA	WOUND CARE	Region (circle):	WNY	CNY
Member Name:				SOC Date:			
Insurance ID#:				Member DOB:			
NEW Diagnosis:				PAST Diagnosis:			
ICD9:							

Homebound Due To:
<input type="checkbox"/> Needs assistance for all activities <input type="checkbox"/> Requires assistance to ambulate <input type="checkbox"/> Confusion, unable to go out of home alone <input type="checkbox"/> Unable to safely leave home unassisted <input type="checkbox"/> Severe SOB, SOB upon exertion <input type="checkbox"/> Dependent upon adaptive device(s) <input type="checkbox"/> Medical restrictions <input type="checkbox"/> Other (specify) _____

Ambulation:
Walks _____ How many feet? _____ Device _____ Assist _____ Balance <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Transfer:
<input type="checkbox"/> Independent <input type="checkbox"/> Min. Assist. <input type="checkbox"/> Mod. Assist <input type="checkbox"/> Max. Assist

ADL:
<input type="checkbox"/> Independent <input type="checkbox"/> Min. Assist. <input type="checkbox"/> Mod. Assist <input type="checkbox"/> Max. Assist

Nursing Agency:
<input type="checkbox"/> VNA of _____ <input type="checkbox"/> _____ County Health Dept.

Member/Family Compliance with POC/Availability/Ability to learn:			
Primary Care Physician (PCP):		Ordering MD:	
Restrictions / WB Status:		Significant psychosocial issues:	
Current Clinical Status (justification for further visits) i.e., wound size, etc.:			
Number of visits made to date:		Projected Discharge Date:	
Requesting continued services: (circle one) Yes No		Requested continued frequency:	
HHA Frequency requested:	HHA SOC:	From:	Through:
Signature:		Title:	Date:

FOR UNIVERA HEALTHCARE USE ONLY			
Date/Time:	Authorization received by Univera Healthcare Rep (Name):		
For:	Visits by (circle) RN MSW HHA INFUSION RN	From:	Through:
Authorization #:	Total # of visits authorized:	Code Authorized:	Through: