Cigna HealthSpring

Phone: **1-888-454-0013**
Fax: **1-800-931-0145**
Web Portal: **http://hsconnect.bravohealth.com**

FORM AUTHORIZATION HOME CARE

****When requesting additional services, please fax all clinical with supporting medical necessity supporting this request to the above listed fax number. Please PRINT:**

Agency Name: ____________________ Initial Start of Care: ____________________

Agency Contact: ____________________ Phone: ____________ Fax: ____________

Member Name: ____________________ DOB: ____________ ID# or Auth#: ____________

Member Contact Number: ____________________ Referral Date: ____________ Number of Visits: ____________

Physician Name: ____________________ Physician Number: ____________________

Was member recently discharged from the hospital: ☐ Yes ☐ No Facility Name: ____________ Discharge Date: ____________

Homebound Status: ☐ Yes ☐ No

CMS Defined: Homebound status certified by MD, leaving the home is a considerable and taxing effort, infrequent and short duration or are attributable to receive health care treatment. Please provide supporting documentation.

Please provide # of visits being requested with date range for each:

	RN	PT	OT	MSW	HHA	ST
Visits						
Dates						

Diagnosis in order of severity	Problems List	Discharge plan initiated & barriers to care

Please complete the following:

Mental Status

☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Depressed ☐ Lethargic ☐ Comatose ☐ Other

Medications name & dosage	Start date	Medication change *Yes or No*	Frequency	Route	Compliance *Yes or No*

DME equipment being used	DME functional	Frequency	Comments include dose/rate if applicable

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Skilled needs	Plan of care (Please include instructions on when education occurred and to whom.)

	Interventions
HPTN: BP __________/__________ Date ____________ Diabetes : blood sugar ____________ Date ___________ CHF/COPD – lung assessment	

Safety issues & interventions	Social Issues

Wound assessment

(Please attach additional sheet for multiple wounds)

Size: Length ______________ Width ______________ Depth _________________

Type: ☐ Pressure Ulcer (Stage __________) ☐ Diabetic ☐ Stasis ☐ Ischemic ☐ Surgical Wound ☐ Burn

Granulating ___%, Slough ___%, Necrotic ___%, Raw/Red ___%, Raw/Pink ___%, White ___%

Wound Edges: ☐ Fused ☐ Detached ☐ Tunneling *Yes or No* ☐ Undermining *Yes or No*

Exudate: ☐ None ☐ Small ☐ Moderate ☐ Large ☐ Copius ☐ Odor *Yes or No*

Exudate Type: ☐ Serous ☐ Serosanguinous ☐ Purulent ☐ Bloody ☐ Tan ☐ Yellow/Green ☐ Clear

Surrounding Skin: ☐ Intact ☐ Erythematous ☐ Denuded ☐ Macerated ☐ Blistered ☐ Necrotic ☐ Edematous ☐ Indurate

Wound care orders, treatment and goals	Goals
(Note change in orders or visit to wound clinic.)	MD appt _________________ OCN Visit Date: _________________ Can Member or caregiver perform treatment? ☐ Yes ☐ No Date of education: _________________

Comments	Additional details
(Please indicate Flu appt. by PCP or physician.)	

Clinician's signature: ____ Date: ______________________

Attending Physician's name and telephone number: ____

Additional Wound Assessment

Wound assessment
Size: _______________ Length _______________ Width _______________ Depth _________________
Type: ☐ Pressure Ulcer (Stage __________) ☐ Diabetic ☐ Stasis ☐ Ischemic ☐ Surgical Wound ☐ Burn
Granulating ___%, Slough ___%, Necrotic ___%, Raw/Red ___%, Raw/Pink ___%, White ___%
Wound Edges: ☐ Fused ☐ Detached ☐ Tunneling *Yes or No* ☐ Undermining *Yes or No*
Exudate: ☐ None ☐ Small ☐ Moderate ☐ Large ☐ Copius ☐ Odor *Yes or No*
Exudate Type: ☐ Serous ☐ Serosanguinous ☐ Purulent ☐ Bloody ☐ Tan ☐ Yellow/Green ☐ Clear
Surrounding Skin: ☐ Intact ☐ Erythematous ☐ Denuded ☐ Macerated ☐ Blistered ☐ Necrotic ☐ Edematous ☐ Indurate

Wound care orders, treatment and goals	Goals
(Note change in orders or visit to wound clinic.)	MD appt _________________ OCN Visit Date: _________________ Can Member or caregiver perform treatment? ☐ Yes ☐ No Date of education: _________________

Wound assessment
Size: _______________ Length _______________ Width _______________ Depth _________________
Type: ☐ Pressure Ulcer (Stage __________) ☐ Diabetic ☐ Stasis ☐ Ischemic ☐ Surgical Wound ☐ Burn
Granulating ___%, Slough ___%, Necrotic ___%, Raw/Red ___%, Raw/Pink ___%, White ___%
Wound Edges: ☐ Fused ☐ Detached ☐ Tunneling *Yes or No* ☐ Undermining *Yes or No*
Exudate: ☐ None ☐ Small ☐ Moderate ☐ Large ☐ Copius ☐ Odor *Yes or No*
Exudate Type: ☐ Serous ☐ Serosanguinous ☐ Purulent ☐ Bloody ☐ Tan ☐ Yellow/Green ☐ Clear
Surrounding Skin: ☐ Intact ☐ Erythematous ☐ Denuded ☐ Macerated ☐ Blistered ☐ Necrotic ☐ Edematous ☐ Indurate

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Clinician's signature: ____ Date: ____________________

Attending Physician's name and telephone number: ____