PRIOR AUTHORIZATION

Medicare Advantage Home Health Care (HHC) fax request form

Providers: you must get Prior Authorization (PA) for HHC. PA is not guarantee of payment. Payment is subject to coverage, patient eligibility and contractual limitations. **Please use appropriate form for Durable Medical Equipment (DME) and Generic PA requests**.

Date _____/_____/_____

Request Type

☐ Concurrent review request

Start of Care Date:
OR
Last Covered Day:

What is being Requested?
☐ Initial Request ☐ Extension ☐ Recertification

☐ Expedited Requests-May take up to 72 hours.

I certify that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

_____
Provider signature required

Patient name And phone number	Requesting provider	Provider NPI #
Patient ID #	HHC Agency	HHC NPI #
Patient birthdate	Contact name	
Initial care start date	Contact phone #	Contact fax #

Was patient discharged from hospital in past 30 days?
☐ No
☐ Yes, patient was discharged on _____/_____/_____ Facility name _____
Attending physician _____ Attending physician phone # _____

Is patient homebound?
☐ No ☐ Yes. Please provide supporting documentation.

ICD-10 code
ICD-10 code
ICD-10 code
ICD-10 code
ICD-10 code

Able/Willing teachable Caregiver? ☐ Yes ☐ No If No Explain:

Please submit the following Clinical Documentation:

- **SOC Recertification/Resumption Oasis Documents (as applicable) and Therapy Evaluations**
- **485/Orders**
- **Wound Notes**
- **Supporting Clinical Documentation (Clinical visit notes from last 14 days, Physician progress notes, H&P, Hospital Discharge, etc...)**
- **Include NOMNC/Discharge Summary/for customer discharged from HH in last 60 days**
- **Discharge/Transfer Oasis and NOMNC**

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. © 2020 Cigna

Please provide total # of visits that have already been completed

	RN	PT	OT	ST	MSW	HHA
# of visits already completed						
Dates of Service						

Home Health Services Requested	Services Providing
☐ Skilled Nursing Plan of Care Frequency:	☐ Wound Care ☐ Foley of PEG care ☐ Access Care ☐ Skilled Teaching ☐ Injections/Infusion ☐ Other
☐ PT ☐ OT ☐ ST (All therapy requests should include current level of function and goals/progress toward goals) Plan of Care Frequency:	☐ Evaluation and Treatment ☐ Maintenance Therapy
☐ HHA/MSW Plan of Care Frequency:	Initial Assessment of qualifying Service must be attached

Please fax this form and supportive clinical to Pre-Cert department below by market:

Market	Phone #	Fax #
IL, IN, No. MS, No. GA, East AR	800.453.4464	866.287.5834
AL, FL, NC, SC, So. MS, Atlanta	800.962.3016	800.872.8685
TX, AR, OK	832.553.3456	888.205.8658
MA, PA, DE, DC, KC, CO, NJ	888.454.0013	800.931.0145
TN HHC	866.913.0947	Initial Request: 615.263.5478 Extensions/Other Requests: 615.401.4667

For a list of Cigna Medicare Advantage services requiring PA, visit **MedicareProviders.Cigna.com** or call your state's Pre-Cert Department.