MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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Request and Justification for Skilled Nursing Visits and Home Health Aide Services

I. General Information

Personal Information

Member's Name _____

Member's MassHealth ID Number _____ Telephone Number _____

Other Insurance Information

MassHealth is the payer of last resort. The provider should use diligent efforts to obtain coverage from other insurance sources.

Other Insurance Carrier _____

Policyholder's Name _____

Policy Number _____

Case Manager Name and Contact Number _____

Why is this service not covered under this insurance? _____

Has this insurance carrier changed since the last prior-authorization request? ☐ yes ☐ no

Household Information

Primary Caregivers _____ Relationship _____

_____ Relationship _____

Has there been any change in the member's status that requires additional training of the primary caregivers? If so, please be specific.

_____

_____

Are there other members in the home who also receive skilled nursing visits? If so, list the names and MID numbers of the members and the number of visits per calendar week.

_____

_____

II. Patient Assessment and Summary

Date of Birth _____ Weight _____ Height _____

Primary Medical Diagnosis _____

Secondary Medical Diagnosis _____

Primary Reason for Skilled Nursing Visits _____

Describe in detail the member's current medical status, medical history, current ability to perform self-care (i.e. wound care), injections, etc. and ability to perform activities of daily living.

If applicable, include an updated summary of the past prior-authorization period. Document any change in the member's medical status, including inpatient and/or outpatient hospital visits, frequency of illnesses, changes in plan of care, and calls or visits to the member's physician.

If additional space is required, please attach additional documents.

_____

_____

_____

_____

_____

_____

_____

III. Home Health Aide Services

If requesting home health aide services, indicate member's functional level for all items below.

Cognitive

- ☐ Alert/Oriented
- ☐ Able to Direct Care
- ☐ Impaired/Developmental Delay
- ☐ Disoriented

Bathing

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate Hands-on Assistance
- ☐ Requires Total Assistance, Unable to Participate

Dressing

- ☐ Independent
  - ☐ Lower Body ☐ Upper Body
- ☐ Requires Set-Up/Minimal Assistance
  - ☐ Lower Body ☐ Upper Body
- ☐ Requires Moderate Hands-On Assistance
  - ☐ Lower Body ☐ Upper Body
- ☐ Requires Total Assistance, Unable to Participate

Toileting

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate/Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Ambulation

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate/Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Grooming

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate/Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Eating

- ☐ Independent
- ☐ Requires Set-Up/Minimal Assistance
- ☐ Requires Moderate/Hands-On Assistance
- ☐ Requires Total Assistance, Unable to Participate

Range of Motion Exercises

- ☐ Independent
- ☐ Upper Extremities
- ☐ Lower Extremities

Other:

Comments:

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IV. Health-Related Services Currently Provided to the Member

Check all services used by the member. Indicate the frequency and payer.

Service	Yes	No	Frequency and Payer
Physical Therapy	☐	☐	
Occupational Therapy	☐	☐	
Speech/Language Therapy	☐	☐	
Intermittent Skilled Nursing Visits	☐	☐	
Home Health Aide	☐	☐	
Personal Care Attendant	☐	☐	
Adult Day Health	☐	☐	
Adult Foster Care	☐	☐	
Hospice	☐	☐	
Palliative Care	☐	☐	
Day Habilitation	☐	☐	
MassHealth Waiver Services	☐	☐	
Other: _____	☐	☐	

V. Services Provided by Other Agencies

If applicable, list services (including respite and case management) that are provided by other sources, such as the Massachusetts Commission for the Blind, the Department of Public Health, the Department of Children and Families, the Department of Education, the Department of Mental Health, the Department of Developmental Services, and an early intervention program. Indicate the frequency of service and the name and telephone number of the case manager.

VI. Request for Skilled Nursing Visits and Home Health Aide Visits

Service Request	From	To	Number of Visits	Frequency
Skilled Nursing Visit				
Home Health Aide				

Current MassHealth Prior Authorization (if applicable)

PA Number _____ Expiration Date _____

Number of skilled nursing visits authorized per week _____

Home health aide hours authorized per week _____

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VII. Names and Signatures

Home Health Agency Name _____

Address _____

Telephone Number _____

Nurse from Home Health Agency _____

Name _____ Telephone Number _____

Signature _____ Date _____

Physician's Name _____ Telephone Number _____

IMPORTANT: When submitting a Prior Authorization Request, submit this form, along with the initial assessment note, the current Physician Plan of Care, and the last two weeks of skilled nursing visits and home health aide notes. Failure to complete all sections on this document may result in a delay in processing.

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