MASSACHUSETTS STANDARD FORM FOR HOME HEALTH PRIOR AUTHORIZATION REQUESTS

S.O.C. Date:	Initial: ☐	Reauthorization Date:
Agency D/C Date: Anticipated: ☐ Actual: ☐	MD Agrees: ☐ Yes ☐ No	Patient Agrees: ☐ Yes ☐ No

PATIENT INFORMATION	AGENCY INFORMATION
Name:	Agency Name:
S.O.C. Address Line 1:	Provider Number:
S.O.C. Address Line 2:	Contact:
Place of Service:	Phone: Fax:
Phone:	**REQUESTING PROVIDER INFORMATION**
DOB:	☐ Contact information same as Agency information listed above.
Rogers Order: ☐ Yes ☐ No ☐ N/A	Ordering MD:
Insurance Number:	MD Phone:
Auth Number:	PCP:
Homebound: ☐ Yes ☐ No Why?	NPI#:
Diagnosis:	Date of Next MD Visit:
Primary:	**DME/SUPPLIES/IV/LAB**
Secondary:	Vendor Name:
Surgery: ☐ N/A	**COMMUNITY RESOURCES/HEALTH-RELATED SERVICES *(Please list below.)***
CAREGIVER INFORMATION	
Name:	**MATERNITY CARE**
Relationship:	☐ N/A
Type of Assistance:	Delivery Date:
Teachable/Not Teachable:	Time of Delivery:
Primary Phone:	**HOSPITAL INFORMATION (AS NEEDED)**
	Hospital Admission Date:
	Hospital Discharge Date:
	Hospital Diagnosis:

CURRENT FUNCTIONAL STATUS		
	STATUS	**AMOUNT OF ASSIST NEEDED OR TYPE OF ASSISTIVE DEVICE**
Cognitive	☐ Alert/Oriented ☐ Impaired ☐ Disoriented	
Dress Lower Extremities	☐ Independent ☐ Requires Assist ☐ Unable	
Dress Upper Extremities	☐ Independent ☐ Requires Assist ☐ Unable	
Bathing	☐ Independent ☐ Requires Assist ☐ Unable	
Toileting/Continence	☐ Independent ☐ Requires Assist ☐ Unable	
Ambulation	☐ Independent ☐ Requires Assist ☐ Unable	

(continued on next page)

MASSACHUSETTS STANDARD FORM FOR HOME HEALTH PRIOR AUTHORIZATION REQUESTS (*CONTINUED*)

CURRENT FUNCTIONAL STATUS *(CONTINUED)*		
	STATUS	**AMOUNT OF ASSIST NEEDED OR TYPE OF ASSISTIVE DEVICE**
Eating	☐ Independent ☐ Requires Assist ☐ Unable	
Transfer	☐ Independent ☐ Requires Assist ☐ Unable	
Grooming	☐ Independent ☐ Requires Assist ☐ Unable	

SERVICE REQUEST	CPT/HCPC CODE	FROM	TO	NUMBER OF VISITS/UNITS	FREQUENCY
RN					
LPN					
HHA/Hours and Visits					
PT					
OT					
ST					
MSW					
Other					

COMMUNICATION		
Comments:		
Name:	Title:	Date:
Patient Name:	Agency:	Auth Number:

SKILLED NURSING		
D/C Date:	Anticipated: ☐	Actual: ☐
Clinical Summary:		
Reason for Home Health Aide Services:		

WOUND CARE N/A ☐	WOUND 1	WOUND 2	WOUND 3
Location			
Appearance			
Measurement			
Drainage			
TX and Frequency			

MEDICATIONS		
Compliant: ☐ Yes ☐ No	Member/Caregiver Able to Learn: ☐ Yes ☐ No	Med List Attached: ☐ N/A ☐ Yes

(continued on next page)

Goals/Plan for this Authorization Period:		
Barriers to Achieve Goals/Plan:		
Interventions:		
Signature:	Title:	Department:

OTHER SKILLED DISCIPLINES				
D/C Date: Anticipated: ☐ Actual: ☐ *Please complete a separate p. 2 when more than one skilled discipline is providing care.*				
PT:	OT:	ST:	MSW:	Other:
Clinical Summary:				
Reason for Home Health Aide Services:				

Goals/Plan for this Authorization Period:
Barriers to Achieve Goals/Plan:
Interventions: