

**AUTHORIZATION REQUEST FOR HOME HEALTH RN VISITS**  
**Fax to 1-800-685-5231**

Home Health Provider Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax from Name: \_\_\_\_\_

Member Name: \_\_\_\_\_

Request Type:     New     Ongoing Authorization # \_\_\_\_\_



**Number of Visits Requested** (include frequency and duration): \_\_\_\_\_

**Reason for Request:** Provide detailed update to support request:

**Bladder:** \_\_\_\_\_

**Bowel:** \_\_\_\_\_

**CV:** \_\_\_\_\_

**Diabetes:** \_\_\_\_\_

**Hematology:** \_\_\_\_\_

**Injections:** \_\_\_\_\_

**Neuro:** \_\_\_\_\_

**Pain Management:** \_\_\_\_\_

**Peripheral Vascular:** \_\_\_\_\_

**Psychiatric:** \_\_\_\_\_

**Resp:** \_\_\_\_\_

**Wound** (include all wounds, measurements, description and treatment):  
\_\_\_\_\_

**Other:** \_\_\_\_\_

**Home Setting/Teaching or Discharge Goals:**  
(include support system and self care info):

---

---

---

---

**Next Physician Appointment:** \_\_\_\_\_