



Request for Necessary Medical Information for Prior Authorization
URGENT REQUEST FOR CONTINUING HOME HEALTH SERVICES

WARNING: THIS FAX CONTAINS PRIVATE AND CONFIDENTIAL INFORMATION

The personal or medical information contained in the fax message is confidential, private and privileged. It is unlawful for unauthorized persons to review, copy, disclose or disseminate confidential medical information. If the reader of this warning is not the intended fax message recipient or the intended recipient's agent, you are hereby notified that you have received the fax message in error and that review or further disclosure of the information contained therein to any other unauthorized person is strictly prohibited. If you have received this fax message in error, please notify us immediately at the telephone number indicated above and return the original to us by mail.

Patient Information

Patient Name	Subscriber ID #
Date of Birth	Today's Date

Provider Information

Facility Name	Facility Tax ID #
Telephone #	Fax
Requesting Physician Name	ICD-9 Code
Facility Contact Person	Telephone # of Contact Person

In order to process the prior authorization request for home health services regarding the above patient, complete the information requested below and return this form to the Health Net Prior Authorization Department by fax at (800) 672-2135.

Please ensure that all information is legible and that only standard abbreviations are used.

SERVICES TO BE PROVIDED
1. Type of services (for example, wound care, teaching, infusion):
2. Frequency of services:
3. How many visits are being requested?
4. How many visits have already been performed?
5. a. Start date of service: b. Anticipated completion date of services:

WOUND CARE
6. Current size of wound: Length _____ Width _____ Depth _____ Type _____ Amount of drainage _____

7. Type of wound care being performed:
8. Date and type of surgery or description of etiology of wound (for example, diabetic ulcer):

HOME INFUSION
9. Type of medication:
10. Frequency of services:
11. Is medication also being requested or is this request just for nursing? If medication is also being requested, please attach documentation describing patient's clinical diagnosis and medical records supporting the diagnosis, including applicable lab data.

HOME IV THERAPY
12. Type of medication:
13. Frequency of dosing:
14. Describe family/patient's ability/inability to self administer:
15. Diagnosis:

HOME HEALTH TEACHING
16. Document teaching needs, date teaching has been performed, and patient/family response to teaching:

ADDITIONAL QUESTIONS
17. Other services, please describe:
18. When will patient be independent in care? What steps are being taken to discharge from service and when is discharge anticipated?

Please attach physician's order and documentation confirming homebound status and any additional documentation supporting this request to the back of this form.

Fax the requested information to:

Health Net Prior Authorization Department
(800) 672-2135