

Estimated Length of Stay		Next MD Appointment			
Living Arrangements					
Caregiver Availability: Willing and Able Caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Lives with Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Relationship: _____					
Community Resources: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Explain/List:					
Please check referrals for any additional services:					
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> Speech Therapy		<input type="checkbox"/> Occupational Therapy	
<input type="checkbox"/> Medical Social Worker		<input type="checkbox"/> Home Health Aide		<input type="checkbox"/> RN	
REQUESTED VISITS AND DATE RANGES FOR EACH DISCIPLINE					
RN:	PT:	OT:	ST:	AIDE:	MSW:
Dates:	Dates:	Dates:	Dates:	Dates:	Dates:
Discharge Date		Signature of Home Health Agency Nurse			
If request for extension of services: Specific reasons for continued service, progress, or any other pertinent information related to extension of services:					
ADDITIONAL COMMENTS					
Completed by			Date		
Title		Phone #		Fax #	
FOR INTERNAL USE ONLY					
Decision <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED		Initial Reviewer			
Nurse Reviewer		#Visits Approved		Total # of Visits to Date	
Review Date		Call Back Date			

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Complete ALL information on the form. NOTE: The prescribing physician (PCP or Specialist) should, in most cases, complete the form.
2. Please provide the physician address as it is required for physician notification.
4. Fax the completed form and all clinical documentation to 1-888-567-5703,
Or mail the completed form to: **PAPHM-043B
Clinical Services
120 Fifth Avenue
Pittsburgh, PA 15222**

For a complete list of services requiring authorization, please access the Authorization Requirements page on the Highmark Provider Resource Center under Claims, Payment & Reimbursement > Procedure/Service Requiring Prior Authorization or by the following link: <https://hwvbcbs.highmarkprc.com/Claims-Payment-Reimbursement/Outpatient-Procedures-Service-Requiring-Prior-Authorization>