# Home Care Authorization Form

CareFirst Family of health care plans

## IMPORTANT

1. Claims submitted for these benefits are subject to lifetime maximums and any applicable deductions, coinsurances or provisions, as specified in the member's contract. Benefits issued for requested services will be subtracted from the member's lifetime benefit maximum. Benefit approval is subject to the following conditions: a) member identification number is effective at the time services are rendered, b) requested benefits are available under the member's contract, c) lifetime benefits not exhausted.
2. When submitting claims for habilitative services, the modifier 96 must be included. When submitting claims for rehabilitative services, the modifier 97 must be included.
3. Please fax home care requests to 410-505-2588 for CareFirst members who are currently hospitalized.
4. Please fax home care requests for CareFirst members who are not currently hospitalized to 410-720-5630 or 410-720-5641. Participating providers should enter their request into CareFirst Direct at carefirst.com rather than send a fax.
5. If you have any questions regarding the extent of this authorization, please call 800-334-3427 ext 4402. Calls will be returned within one business day.

## HOME CARE PROVIDER INFORMATION

| | | |
|---|---|---|
| Home Care Provider | Provider Phone # | Agency Contact Name |
| Home Care Provider Address | Provider Fax # | Start of Care (SOC) Date |
| | Provider ID # | Date of Request |
| | Email Address | |

## MEMBER/PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Last Name | First Name | M.I. | Gender | Date of Birth |
| Address (Street, Apt. or Box #), City | State | | | Zip Code |
| Member Group # | Member ID # w/Prefix | | | |
| Place of Hospitalization | Hospital Admission Date | | | Hospital Discharge Date |
| Physician's Name and Complete Address | | | | |
| Diagnosis & Code(s) (ICD-10) | Homebound | | | |

Services requested (include number of visits per day/week/month)

- ◯ Skilled Nursing (SN)
- ◯ Physical Therapy (PT)
- ◯ Nutritionist
- ◯ Speech Therapy
- ◯ Medical Social Worker (MSW)
- ◯ Home Health Aide (HHA)
- ◯ Occupational Therapy (OT)
- ◯ Private Duty Nursing (PDN) Hours per day_____





CUT6137-1E (11/23)

## MEMBER/PATIENT INFORMATION

Wound Present ◯ Yes ◯ No

Location _____
*If yes; must complete

1. Measurements: _____ Length _____ Width _____ Depth

2. Measurements: _____ Length _____ Width _____ Depth

Presence of Tunneling ◯ Yes ◯ No

Drainage _____ Color _____ Odor _____ Amount

Caregiver or Member instructed in wound care
◯ Yes ◯ No

Wound Vac?
◯ Yes ◯ No

## INTERNAL OFFICE USE ONLY

Authorization # and Date

SN _____ PT _____ OT _____ MSW _____ HHA _____

SLP _____ Other _____