

**Home Care Extension Request Form**

Home Care Provider	Provider Phone Number	Member's Group Name
Home Care Provider Address	Provider Fax Number	Member's Group Number
Home Care Provider Address	Provider Number	Member Number w/ Prefix

Agency Contact Name:		SOC Date:		Date of Request:	
Patient's Last Name:		First Name:	M.I.:	Gender:	Date of Birth:
Next Scheduled Appointment:		Diagnosis Code(s):			Homebound:
<b>Services Requested (include number of visits per day/week/month)</b>					
Skilled Nursing	_____	MSW	_____		
Physical Therapy	_____	HHA	_____		
Nutritionist	_____	OT	_____		
Speech Therapy	_____	PDN	_____	hrs per day	_____
<b>Actual Visit Dates During Previous Auth Period for each Discipline</b>					
_____					
_____					
Wound present: <input type="checkbox"/> Yes <input type="checkbox"/> No			C/G or Mbr instructed in wound care:		
Location: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>* If yes; must complete:</b>			Drainage: _____ color    _____ odor		
1 - Measurements:    _____ length    _____ width    _____ depth			_____ amount		
2 - Measurements:    _____ length    _____ width    _____ depth					
Presence of Tunneling: <input type="checkbox"/> Yes <input type="checkbox"/> No					

Progress Report (include goals):  
 \_\_\_\_\_  
 \_\_\_\_\_

Internal Office Use Only	
Certification # and Dates	_____
	_____ SN    _____ PT    _____ OT    _____ MSW    _____ HHA    _____ SLP    _____ Other _____
	_____

**Important  
Please Read**

1. Claims submitted for these benefits are subject to lifetime maximums, any applicable deductions, or coinsurances or provisions as specified in the contract. Benefits will be subtracted from the patient's lifetime benefits. This approval is subject to the following conditions: a) the membership is in effect at the time the services are rendered, b) these specific benefits are available under the particular contract for which the patient is insured, and c) non-exhaustion of lifetime benefits. In order to assure that benefits are available under patient's contract, please contact the appropriate benefit and eligibility verification area.
2. Payment of the claim for the approved services does not mean that future services will automatically be paid. All future claims for services similar to the above services have to be evaluated in accordance with the existing criteria.
3. If you have any questions regarding the extent of this authorization, please call (800) 334-3427 ext. 4402. Calls will be responded to within one business day.

**Fax completed form to (410)720-5630 or (410)720-5641.**  
 Please contact provider services to verify member's eligibility and benefits for the requested service.