

## Home Care Extension Request Form

Home Care Provider	Provider Phone Number	Agency Contact Name
Home Care Provider Address	Provider Fax Number	Start of Care (SOC) Date
	Provider ID Number	Date of Request

Patient's Last Name	First Name	M.I.	Gender	Date of Birth
Address (Street, and Apt or Box Number), City		State	Zip Code	
Member Group Number		Member ID Number w/Prefix		

Next Scheduled Appointment	Diagnosis & Code(s)	Homebound
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Services requested (include number of visits per day/week/month):

<input type="checkbox"/> Skilled Nursing (SN) _____	<input type="checkbox"/> Medical Social Worker (MSW) _____
<input type="checkbox"/> Physical Therapy (PT) _____	<input type="checkbox"/> Home Health Aide (HHA) _____
<input type="checkbox"/> Nutritionist _____	<input type="checkbox"/> Occupational Therapy (OT) _____
<input type="checkbox"/> Speech Therapy _____	<input type="checkbox"/> Private Duty Nursing (PDN) _____ Hours per day _____

Actual Visit Dates During Previous Auth Period for each Discipline

Wound Present: <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____ *If yes; must complete: 1 – Measurements: _____ length _____ width _____ depth 2 – Measurements: _____ length _____ width _____ depth Presence of Tunneling: <input type="checkbox"/> Yes <input type="checkbox"/> No Drainage: _____ color _____ odor _____ amount	Caregiver or Member instructed in wound care: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Progress Report (include goals):

**INTERNAL OFFICE USE ONLY:**

Certification # and Dates:	SN _____ PT _____ OT _____ MSW _____ HHA _____ SLP _____ Other _____
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**IMPORTANT, PLEASE READ:**

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. Please contact the appropriate provider service area to verify member's eligibility and benefits for requested services.
3. Claim payment for approved services does not indicate payment for future services. All future claims will be evaluated in accordance with the aforementioned benefit approval conditions and the CareFirst and/or CareFirst BlueChoice utilization management review process.
4. 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.

**Fax completed form to (410) 720-5630 or (410) 720-5641.**