care n care
Insurance Company, Inc.

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Home Health Pre-Certification Form

Phone: 855-359-9999 Fax: 855-446-9982

ONLY COMPLETED FORMS WILL BE PROCESSED

HOME HEALTH AGENCY NPI#	PCP NPI#
REQUESTING PROVIDER NPI#	

Eval:______ Initial Recert:_________ Resumption of Care:__________

REQUESTOR AND PATIENT INFORMATION	
Agency Name:	Contact Person:
Phone:	Fax:
Patient:	Patient ID#/DOB:
PCP:	Ordering Physician:
Diagnosis Related to HH Need:	

SKILLED NURSING SERVICES

# of visits requested:________________________ 485 Dates of Service: -

PT

# of visits requested:________________________ 485 Dates of Service: -

OT

# of visits requested:________________________ 485 Dates of Service: -

SPEECH THERAPY

# of visits requested:________________________ 485 Dates of Service: -

MSW

# of visits requested:________________________ 485 Dates of Service: -

HHA

# of visits requested:________________________ 485 Dates of Service: -

485 orders are required for all initial SOC requests.

A **SN summary** documenting current clinical status with skilled need is required for all **SN recert** requests. Please do not send the Oasis.

Examples of acceptable SN summary documentation:

- Change in condition – describe what changes in patient's condition have occurred
- Unstable condition – describe unstable condition and attach supporting documentation; examples include vital signs log, PT/INR log, blood sugar log, other abnormal labs that require SN intervention
- New and changed meds within 14 days – describe what meds have changed or been added
- Wound clinical with photo; new photo required every 30 days to show progression Submit therapy evaluations and notes for all therapy services being requested.

Submit therapy evaluations and notes for all therapy services being requested.

Describe circumstances that require skilled services: ______________________________

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