CLEAR FORM

Physicians Health Plan

P.O. Box 30377
Lansing, MI 48909-7877
Phone: 517.364.8560 Fax: 517.364.8409

Home Health Care Request Form

Instructions: All sections must be completely filled out for review. Please fax the completed form and relevant chart notes to 517.364.8409 Monday-Friday, 8am-5pm, except holidays

Patient Information	Prescriber Information
Today's date:	Referring Provider's name:
Member name:	Office phone: Fax:
Member's PHP ID#:	Office contact:
Date of birth:	Patient's Primary Physician:

Treatment/Request Information

☐ New Request ☐ Extension, authorization # _____

ICD9/10 Diagnosis code:	Anticipated start of care date:

Visit type:

☐ SN	Number of Visits Requested: _____	Dates of service: from _____ to _____
☐ PT	Number of Visits Requested: _____	Dates of service: from _____ to _____
☐ OT	Number of Visits Requested: _____	Dates of service: from _____ to _____
☐ ST	Number of Visits Requested: _____	Dates of service: from _____ to _____
☐ SW	Number of Visits Requested: _____	Dates of service: from _____ to _____
☐ Aide	Number of Visits Requested: _____	Dates of service: from _____ to _____

Home Health Contact Person & Title:	Agency: *(include address, city, state, zip)*	
Provider #:	Phone:	Fax:

Description of skilled services *(e.g. SNV dressing changes daily for wound, IV therapy – drug/dose/frequency, PT for gait training, OT for upper body strength)*

OUTCOME (*PHP use only*)

☐ Approved as requested ☐ Approved with changes Authorization number: _____

_____ Number of visits approved: _____ Dates of service From: _____ To: _____

_____ Number of visits approved: _____ Dates of service From: _____ To: _____

_____ Number of visits approved: _____ Dates of service From: _____ To: _____

PHP MRM Reviewer Name: _____ Date: _____

03.14.17

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