UnitedHealthcare®
Options PPO Network

Independent Health Home Health Care Request Form

Phone: (716) 631-3282 Fax: (716) 635-3663

Request for infusion *medications* requiring prior IH approval should be faxed to Pharmacy: (716) 631-9636

REQUEST FOR: ☐ **IH MEDICAL**

NOTE: ALL fields on this form must be completed. If not, delay of determination may result. Please be advised that Independent Health must have the necessary information to process the request timely.

MEMBER INFORMATION:

***MEMBER ID:** ☐☐☐☐☐☐☐☐☐ **SUFFIX:** ☐☐

***NAME:** ______________________________ **DOB:** ____________________

Home/Cell Phone: (_____) ________-__________ Address: ______________________________ State: ______ Zip code: ________

REQUESTING PHYSICIAN/PRACTITIONER INFORMATION:

***NAME:** ______________________________ **NPI:** *☐☐☐☐☐☐☐☐☐☐*

Office Contact Name: ______________________________ **TAX ID:** *☐☐-☐☐☐☐☐☐☐*

Phone number: ____________________ ext: __________ Fax: ____________________

HOME CARE AGENCY INFORMATION:

***NAME:** ______________________________ **NPI:** *☐☐☐☐☐☐☐☐☐☐*

Office Contact Name: ______________________________ **TAX ID:** *☐☐-☐☐☐☐☐☐☐*

Phone number: ____________________ ext: __________ Fax: ____________________

DIAGNOSIS CODES (ICD-10): 1. ______________ 2. ______________ 3. ______________

REQUESTED SERVICES (as requested service pertains):

Please check the box of the correct choice below.

☐ **Update to Existing Certification Period of:** ____________________

☐ **New Certification Period of:** ______________________________

Service Requested	Units	Start Date	End Date
Skilled Nursing (SN) – (RN/LPN)			
Maternal/Newborn (99500-99502)			
Physical Therapy (PT)			
Occupational Therapy (OT)			
Speech Therapy (ST)			
Home Health Aide (HHA)			
Medical Social Work (MSW)			

Would processing this request after seventy-two (72) hours, place the member's life, health or ability to regain maximum function in serious jeopardy? ☐**NO** ☐**YES**