



Authorization for Home Health is not required until the seventh visit.  
 Members are allowed six home health visits per calendar year without an authorization

## Passport by Molina Healthcare Home health request form

Member Name \_\_\_\_\_ Member ID \_\_\_\_\_ Member DOB \_\_\_\_\_

Rendering Provider Name \_\_\_\_\_ Tax ID \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Ordering Provider Name \_\_\_\_\_ Tax ID \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

A. Services Requested

| Service Type         | Service Code(s) | Start Date | End Date | Frequency                           | Goal of Care | % of Goal<br>For continued visits |
|----------------------|-----------------|------------|----------|-------------------------------------|--------------|-----------------------------------|
| Skilled Nursing      |                 |            |          | <#> time a week<br>for <#> of weeks |              |                                   |
| Physical Therapy     |                 |            |          | <#> time a week<br>for <#> of weeks |              |                                   |
| Occupational Therapy |                 |            |          | <#> time a week<br>for <#> of weeks |              |                                   |
| Speech Therapy       |                 |            |          | <#> time a week<br>for <#> of weeks |              |                                   |
| Home Health Aide     |                 |            |          | <#> time a week<br>for <#> of weeks |              |                                   |
| Other<br><specify>   |                 |            |          | <#> time a week<br>for <#> of weeks |              |                                   |

**Prior Visits:**

| Service Type | To | From | Total Number of Visits |
|--------------|----|------|------------------------|
|              |    |      |                        |
|              |    |      |                        |
|              |    |      |                        |

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.

B. Diagnoses

a. Primary: \_\_\_\_\_

b. Secondary: \_\_\_\_\_

C. Requesting physician/Provider

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax: \_\_\_\_\_

D. Next Physician/Provider re-evaluation appointment

E. Special Services

Wound Care:

|                        |  |
|------------------------|--|
| Original Size of wound |  |
| Current Size of Wound  |  |

Therapy Services:

|                           |  |
|---------------------------|--|
| Original Status           |  |
| Current Status            |  |
| Current % of meeting goal |  |

Equipment or monitoring requests:

| Equipment / Monitoring request | To be utilized for: |
|--------------------------------|---------------------|
|                                |                     |
|                                |                     |
|                                |                     |

Other:

| List other special service request(s) | To be utilized for: |
|---------------------------------------|---------------------|
|                                       |                     |
|                                       |                     |
|                                       |                     |
|                                       |                     |

*Clinical information and supportive documentation should consist of current physician order, relevant notes supporting the request and recent diagnostics. To determine Medical Necessity, in conjunction with independent professional medical judgment, Passport uses nationally recognized evidence-based guidelines (MCG), third party guidelines, CMS guidelines, state/commonwealth guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.*