Prior Authorization Request for Home Health Services

MedStar Family Choice

Date: _____

MFC - Maryland Fax: (410) 933-2274

Member Name: (*Please print*) _____**DOB:** _____

Member MedStar ID #: _____ **or Medicaid ID #:** _____
(*MD ID begins with **91**…*)

Home Health Agency: _____ **NPI#**_____

Ordering Physician_____ **Provider Phone**_____

Contact Person Name: _____

Contact Phone w/ext: _____ **Contact Fax:** _____

Date of 6th visit: _____

Date(s) of Service requested (date range): _____

# of visits: SN ____ **PT** ____ **OT** ____ **ST** ____

What is the skilled need? _____

Diagnosis Code(s)/ICD-10: _____

CPT/HCPCS Code for services being requested: _____

*****Please include all of the following documents that apply*****

- Most Recent SN, PT, OT or ST visit notes
- Wound measurements/assessment (current)
- Goals and plan to support need for additional visits
- Any New Physicians orders/wound care orders

Revised 5/21/19