CHANGE IN HOME HEALTH SERVICE PLAN OR DISCHARGE FROM SERVICES

(Please print.)

Date: ___/___/_____

Fax the completed form with the required documentation to 1-800-913-2229. This form will be returned unprocessed if incomplete information is provided.

Is beneficiary on HCBS waiver?
(Circle or check)
Yes ___ No ___
If yes, are PCA services:
(Circle or check)
Self ___ or Agency ___ Directed

This request is for:
_____ Change in service plan from Acute to Long-Term Care
_____ Change in service plan from Long-Term Care to Acute
_____ Change in service plan from Acute to Diabetes Management
_____ Change in service plan from Diabetes Management to Acute
_____ Discharge from home health services after an acute episode of care
_____ Other ____

Beneficiary Name ______________________________ Beneficiary ID # ___________________________

Provider Name _________________________ Provider ID # ________________ NPI # ______________

Provider Contact Person _________________________ Provider Phone # ______-______-___________

Provider Fax # ______-______-______________

If eligible for Medicare, why is Medicare not being used? ______________________________________

All fee for service home health care must be prior authorized. Refer to prior authorization criteria in the *Home Health Agency Provider Manual*. The documentation submitted must reflect the need for the level and frequency of care requested.

Acute Care Services – Nursing services – G0156, G0299, G0300, T1002, T1003, T1004, T1023, 99601, 99602

Therapy services – S9128, S9129, S9131, T1021

Long-Term Care Services – Nursing services – G0156, S0316, T1004, T1023, T1031, T1030, T1502 99600, 99601, 99602

Diabetes Management – Nursing services – G0156, S0315, S9460, T1004, T1023, T1030, T1031 99601, 99602

Please complete the following for all services being modified.
Previous service plan (from) and frequency of visits:

Code(s) All codes prior authorized on the previous service plan	**Total Visit Provided** The number of visits used from the previous service plan	**Total Visits Remaining** The number of visits prior authorized but not provided or billed	**Dates From – To** Date the PA began and ended on the previous service plan
Example 30 visits T1002	*10 visits – T1002*	*20 visits T1002*	*3/1/2016 – 3/21/2016*

 Revised 12/2016

Please complete the following for all services being requested.
Desired service plan (to) and frequency of visits:

Code(s) All codes(s) you want to have prior authorized	**Total Units Requested** Total number of visits you expect to bill for the time period specified in the next column	**Dates From – To** Date the PA will begin and end (Dates cannot extend more than six months.)
Example – 250 visits of 99600	***250 visits***	***3/22/2010- 7/22/2010***
Example – 720 visits of S9460	***720 visits***	***3/22/2010 – 9/22/2010***

Please complete the following for all acute care visits that were prior authorized but were not provided prior to discharge from home health services.

Code(s) All code(s) that were prior authorized	**Total Units Requested** Total number of visits that were provided and will be billed	**Dates From – To** Date the PA began and last date of service	**Balance** Acute care visits remaining for the calendar year.
Example – 20 visits of T1002	***10 visits***	***3/1/2010 – 4/30/2010***	***110 visits***
Example – 10 visits of S9131	***10 visits***	***3/1/2010 – 4/30/2010***	***100 visits***

With each change from one home health service plan to another, the provider must use this form to notify the PA unit of the switch or discharge from a plan within five business days of the event.

Fax the completed form with the required documentation to 1-800-913-2229.
This form will be returned unprocessed if incomplete information is provided. The provider will be notified of a decision by a written letter of determination. Verification of the PA entry and determination can also be done through the KMAP website.