Florida complete care

Home Health Care Services Prior Authorization Request Form

FLORIDA COMPLETE CARE (FC2) (the Plans) requires authorization for all Home Health Care Services. The process is meant to maximize efficiencies and ensure that our members' and your patients' home-skilled service needs are met in the timeliest manner possible.

The following is the format by which the Plans will receive requests for all Home Health Care Service requests. Please note that all fields are required to be filled in. Make sure that there are no blank field(s) before submitting this document.

You can attach additional pages with this document to respond to this document properly and specifically.

Request/ Submission Date:	Service Start/End Dates:

Home Health Agency Name	
Point of Contact	
Contact Phone Number	
Contact eMail Address	
Contact FAX	
Network Participation Status	❒ Participating Agency ❒ Non-participating Agency

Physician/Provider's Prescription Attached (check one): ☐ **Yes** ☐ **No**

Member Last Name	
Member First Name	
Date of Birth	
Member Plan ID Number	
Member Phone Number	
Service Location Type	Residence ❒ ALF ❒ Group Home ❒
County Service Location	
Request Type	Initial Service Request ❒ Ongoing ❒
Principal/Primary Diagnosis	(ICD 10 Code Required)
Secondary Diagnosis	(If Applicable – Use ICD10 Code)
Homebound Status	Homebound Confirmed ❒ Does Not Meet Homebound Status ❒
Ambulatory Status	❒ Ambulatory ❒ Ambulatory with assist device ❒ Non-ambulatory—Bedbound ❒ Non-ambulatory—Wheelchair bound
Skilled Being Requested	**HCPCS/CPT Codes Requested and Skilled Need Justification**

Type of Request: ☐ **Standard** ☐ **Expedited:** **By checking this request, I attest that applying the standard prior authorization process of 7-day time frame will seriously jeopardize the life or health status of the patient or the patient's ability to regain maximum function. The specific details as to how this patient would be in jeopardy or unable to regain maximum function must be documented as additional documentation to this form, signed and dated. That documentation must support the attestation that the patient's need meets the requirement for and expedited review. Upon receipt, the request and accompanying documentation will be reviewed by a plan medical director; and a determination will be made as to the acceptance or rejection for an expedited review. A verbal notification will be made that the expedited request as not granted because the request did not meet the requirement or that there was no proof documentation submitted/received. At that time, the request will be transitioned to a STANDARD review.**

Please note that from time to time, the Plans can update, add, delete, change, or amend this prior authorization form as part of a Quality Improvement Process or as contractually obligated under its contract with the Agency for Health Care Administration or The Centers for Medicare and Medicaid. Proper notice will be given prior to any such action when contractually obligated to do so.

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Skilled Service Required	❒ Skilled Nursing Codes: ❒ Physical Therapy Codes: ❒ Speech Therapy Codes: ❒ Occupational Therapy Codes: ❒ Home Health Aide Codes:
Skilled Nursing *The patient requires skilled service for [what reason]*	
Physical Therapy *The patient requires skilled service for [what reason]*	
Speech Therapy *The patient requires skilled service for [what reason]*	
Occupational Therapy *The patient requires skilled service for [what reason]*	
Home Health Aide *The patient requires to support what skilled service, treatment of current condition*	
Number of Visits Being Requested	**Number of Visits and the Clinical Rationale**
Skilled Nursing	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Home Health Aide	
Goals	**Specifically list the goals below** **(Please include the clinical estimation of how long the goals will take to be achieved)**
Skilled Nursing	❒ Short-term: ❒ Long-term:
Physical Therapy	❒ Short-term: ❒ Long-term:
Speech Therapy	❒ Short-term: ❒ Long-term:
Occupational Therapy	❒ Short-term:

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	❒ Long-term:
Home Health Aide	❒ Short-term: ❒ Long-term:
OASIS	❒ Submitted with this request ❒ Not Submitted with this request
Plan of Care	❒ Submitted with this request ❒ Not submitted with this request

The Home Health Agency should attach any supporting clinical documentation to this request.

For any assistance, please call the Plans' Prior Authorization Department at:

1-833-322-7526

Please submit this document and any supporting information to:

FAX to the Plans' Prior Authorization Department

1--305-675-6138

eMail for the Plans' Prior Authorization Department

fccumdepartment@fcchealthplan.com

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