TUFTS Health Plan

Tufts Health RITogether – Home Health Authorization Form

Fax form to 857.304.6404

Today's date: _____/_____/_____

HOME HEALTH AUTHORIZATION INFORMATION

S.OC. date: _____/_____/_____ Initial: ☐ Reauthorization date: ____/____/_____

Agency D/C date: _____/_____/_____ Anticipated: ☐ Actual: ☐

Provider agrees: ☐ Yes ☐ No Patient agrees: ☐ Yes ☐ No

PATIENT INFORMATION

Name:_____

S.OC address: _____

Phone:_____

DOB:_____/_____/_____

Homebound: ☐ Yes ☐ No

Why? _____

_____

Diagnosis:_____

Surgery: ☐ N/A or _____

Patient prognosis:

☐ Terminal ☐ <6 months to live ☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Very good ☐ Excellent

PROVIDER INFORMATION

Ordering provider:_____

Provider phone:_____

PCP:_____

Date of next provider visit: _____/_____/_____

TUFTS HEALTH RITOGETHER INFORMATION

Insurance #:_____

Health plan CM:_____

Initial authorization #:_____

Phone:_____

Fax:_____

AGENCY INFORMATION

Agency name:_____

Provider phone:_____

Provider fax:_____

DME/SUPPLIES/IV/LAB

Vendor name:_____

Community resources information:_____

_____

CAREGIVER INFORMATION

Name:_____

Relationship:_____

Type of assistance:_____

Teachable/Not teachable:_____

Primary phone:_____

FACILITY INFORMATION

Facility name:_____

Address:_____

Phone:_____

MATERNITY CARE INFORMATION

☐ N/A

Delivery date:_____/_____/_____

Time of delivery:_____:_____

Discharge date:_____/_____/_____

Time of discharge:_____:_____

CURRENT FUNCTIONAL STATUS

Cognitive	Dress lower extremities	Bathing	Toileting	Ambulation
☐ Alert/Oriented ☐ Impaired ☐ Disoriented	☐ Independent ☐ Requires assist ☐ Unable	☐ Independent ☐ Requires assist ☐ Unable	☐ Independent ☐ Requires assist ☐ Unable	☐ Independent ☐ Requires assist ☐ Unable

SERVICE REQUEST INFORMATION

Service request	From	To	# of visits	Frequency	Authorized # of visits	Health plan auth #
RN						
HHA/Hrs & visits						
PT						
OT						
ST						
MSW						
Other						

COMMENTS

_____

_____

_____

_____

Name:_____ Title:_____ Date:_____/_____/_____

SKILLED NURSING

D/C date:_____/_____/_____ ☐ Anticipated ☐ Actual

Clinical summary:

REASON FOR HOME HEALTH AIDE SERVICES

Wound care N/A	Wound 1	Wound 2	Wound 3
Location			
Appearance			
Measurement			
Drainage			
TX and frequency			

MEDICATIONS

Compliant: ☐ Yes ☐ No Teachable patient: ☐ Yes ☐ No Medication list attached: ☐ Yes ☐ No

BARRIERS TO ACHIEVE GOALS/PLAN

INTERVENTIONS

Signature:_____ Title:_____

Department:_____ Date:____/____/_____

OTHER SKILLED DISCIPLINES

D/C date: _____/_____/_____ ☐ Anticipated ☐ Actual

Note: When there is more than one skilled discipline providing care, include this information on a separate page.

☐ PT ☐ OT ☐ ST ☐ MSW ☐ Other

REASON FOR HOME HEALTH AIDE SERVICES

CLINICAL SUMMARY

GOALS/PLAN FOR AUTHORIZATION PERIOD

BARRIERS TO ACHIEVE GOALS/PLAN

INTERVENTIONS

Signature:_____ Title:_____

Department:_____ Date:____/____/_____