

Request*	Home Health	Hospice	Infusion Therapy				
	Initial Therapy	Concurrent Therapy					
Authorization Number*							
Requested Services*							
SN	PT	PTA	OT	OTA	ST	HHA	MSW
Member Information*							
Member Name:							
DOB:							
Member ID:							
Referral Source *							
Referring Provider Name:							
Agency Information*							
Provider Name:							
GHP Provider ID #:							
Phone Number							
Fax Number:							
Requestor's Name :							
ICD 10 Codes*							
ICD 10 Description*							
Start of Care* (enter date)							
Tenth Visit Completion Date *							
Date of Discharge from Previous Episode of Care*							
Resumption of Care Date* (re-admission within 60 days of discharge from previous episode of care with the same or similar diagnosis OR post discharge from inpatient facility)							
Number of Visits Used*							
SN	PT	PTA	OT	OTA	ST	HHA	MSW
Lives*				Caregiver able to assist*			
Alone	With Caregiver	In Facility	Yes	No			

****Please remember to include the most recent visit note from each service for which you are requesting authorization****

***Required Information. Incomplete forms will be returned unprocessed.**

Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.

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