Prestige HEALTH CHOICE®

Leading the Way to Quality Care

Home Care Services Prior Authorization Request

To submit requests, please fax completed form to **1-855-398-561C**
For assistance please contact the **Coordinated Care Unit** at **1-855-371-396C**

Providers are responsible to obtain prior authorization for services prior to providing service. Please submit clinical information and orders as needed to support medical necessity of the request. Requests will not be processed if any of the following information is missing clinical information, specialist and/or primary care clinical summaries, or CPT and ICD-10 codes. As a reminder, authorization is not a guarantee of payment; payment is subject to benefit coverage rules, including member eligibility and any contractual limitations in effect at the time of service. Initial requests should be submitted via our website or fax. For the most up to date listing of services requiring Prior Authorization, visit the Provider Resources page at www.prestigehealthchoice.com or call Provider Services at 1-800-617-5727.

Today's Date:	Requested Start Date of Service:
☐ **Standard Request**	Prestige Health Choice has 7 days to render a decision from date of request, and can extend time frame by an additional 7 days.
☐ **Expedited**	Prestige Health Choice, I certify that applying the standard review time frame may seriously jeopardize the life and health of the member. Prestige has 48 hours to render decision, and can extend time frame by an additional 2 business days. MD Signature:_____

A. Member Information

Medicaid ID number:	Member Last Name:	Member First Name:
Date of Birth:	Member Address:	
ICD-10 Codes:	Member Phone Number:	Gender: ☐ Male ☐ Female

B. Review Type

☐ Home Care ☐ Home Infusion ☐ Initial ☐ *Change DOS/Setting

☐ *Extension of Services ☐ *Additional Clinical ☐ *Cancel ☐ *Other (specify)

*Please Specify (If applicable, previous authorization number): _____

C. Provider Information

Submitting Provider Name:	Contact Name:	Contact Phone Number:	
Contact Fax Number:	NPI#:	Provider Medicaid ID:	☐ Par ☐ Non-Par

Treatment Setting ☐ Home ☐ *Other

*Please specify if other selected: _____

DO NOT write below this line: Fields to be completed by Prestige Health Choice.

Authorization # _____ Prestige CCU Agent Name: _____

Medicaid ID number: _____

Other Clinical Information: Include/attach clinical/office notes, doctor's orders, labs, imaging reports to support medical necessity. If this is an out-of-network request, please provide an explanation, and complete the non-par provider form.

D. Home Care

Name of Agency:	Number of Units/Visits Requested:	Date(s) Requested:
☐ Initial ☐ Extension		
Additional Comments:		

E. IV / Injectable

Last dose given at:	Time given at:
Next dose due at:	Time due at:
☐ PICC Line ☐ Peripheral Line	

F. Enteral Nutrition Therapy

☐ Oral Supplement ☐ Nutrition Pump ☐ Bolus

Formula:	Dosage Frequency:	
Calories per Day:	Or Cans per Day:	Length of Time Needed:

G. Wound Care

☐ Wet to Dry ☐ Dressing Change

Frequency:	Wound Stage:
Location of Wound:	
Diameters: Length:	Width: Depth:

DO NOT write below this line: Fields to be completed by Prestige Health Choice.

Authorization # _____ Prestige CCU Agent Name: _____

Medicaid ID number: _____

Requested Dates of Service: From_____ Through_____

Please select the items/services requested by checking the box(es) below:

HOME CARE OVER 21

✓	CODE	DESCRIPTION	REQUESTED QUANTITY
	97001	PHYSICAL THERAPY EVALUATION	
	97110	PHYSICAL THERAPY VISITS (2 VISITS OR 4 VISITS MAX)	
	T1030	NURSE EVALUATION	
	T1031	SKILLED NURSE VISIT	
	T1030	HIGH TECH NURSE VISIT	
	T1030-U1	HIGH TECH NURSE VISIT - CARE OVER TWO HOURS	
	T1021	HOME HEALTH AIDE VISIT	

HOME CARE UNDER 21

✓	CODE	DESCRIPTION	REQUESTED QUANTITY
	97003	OCCUPATIONAL THERAPY EVALUATION	
	97530	OCCUPATIONAL THERAPY VISITS	
	92523	SPEECH THERAPY EVALUATION	
	92507	SPEECH THERAPY VISITS	
	97001	PHYSICAL THERAPY EVALUATION	
	97110	PHYSICAL THERAPY VISITS	
	T1030	NURSE EVALUATION	
	T1030-U1	HIGH TECH NURSE	
	T1021	HOME HEALTH AIDE VISIT	
	T1022	HOME HEALTH AIDE PER HOUR	
	S9123	PRIVATE DUTY NURSING BY RN 2-24 HOURS	
	S9124	NURSING PER HOUR - LPN	

WOUND CARE SUPPLIES (ALL AGES)

✓	CODE	DESCRIPTION	REQUESTED QUANTITY
	A6216	GAUZE, NON-IMPREGNATED, NON-STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	
	A6402	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	
	A6403	GAUZE, NON-IMPREGNATED, STERILE, PAD SIZE MORE THAN 16 SQ. IN. LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	
	A4927	NON-STERILE GLOVES, PER 100	
	A4450	TAPE, NON-WATERPROOF, PER 18 SQUARE INCHES	
	A4452	TAPE, WATERPROOF, PER 18 SQUARE INCHES	
	A4217	STERILE WATER/SALINE, 500 ML	

IV INJECTABLES

✓	CODE	DESCRIPTION	REQUESTED QUANTITY

ENTERAL NUTRITION

✓	CODE	DESCRIPTION	REQUESTED QUANTITY

OTHER

✓	CODE	DESCRIPTION	REQUESTED QUANTITY

DO NOT write below this line: Fields to be completed by Prestige Health Choice.

Authorization #_____ Prestige CCU Agent Name: _____