Home Care Authorization Request Form

Jefferson Health Plans

General Information		
Today's Date: ____ /____ /_____	Initial Start of Care Date: ____ /____ /_____	
Member Name:	Member ID #:	Member DOB: ____ /____ /_____

Homecare Provider		
Provider Name: Contact Name:	Address (City, State, Zip):	Phone #: Fax #:
PROMISe ID: _____ NPI: _____		

Ordering Physician
Ordering Physician Name:
PROMISe ID: _____ NPI: _____
Principal Diagnosis (ICD 10/Description):
Clinical Info:

Service Requested	Date Range of Visits e.g., 1/1/2026-2/15/2026	Total Number of Visits
☐ R.N.		
☐ P.T.		
☐ O.T.		
☐ S.T		
☐ MSW		
☐ HHA		

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

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R.N.

☐ Assess/Evaluation ☐ Active Co-morbidity ☐ Adjustment in TX/Medication Regime
☐ Cognitive Deficit ☐ Knowledge Deficit ☐ Physical Deficit
☐ New Onset of Symptoms ☐ Wound Care ☐ Wound Present
Measurements: Length: _____ Width: _____ Depth: _____
Goals: _____

P.T.

☐ Assess/Evaluation ☐ Therapeutic Exercises ☐ ADL/Mobility/Transfer Training
☐ HEP ☐ Home Safety ☐ Strength/ROM
☐ *Other:* _____
Goals: _____

O.T.

☐ Assess/Evaluation ☐ Teaching ☐ ADL/Mobility/Transfer Trainin
☐ HEP ☐ Other: _____
Goals: _____

S.T.

☐ Assess/Evaluation ☐ Speech Retraining ☐ Cognitive Deficit
☐ Aspiration Precaution ☐ Feeding Training ☐ Verbal Motor Training
☐ Cognitive Sentence Recognition ☐ Cognitive Word Finding
☐ *Other:* _____
Goals: _____

MSW

☐ Assess/Evaluation ☐ Assistance with Referrals ☐ Long Term/Financial Planning
☐ Family Caregiver Instructions ☐ Other: _____
Goals: _____

HHA

☐ Assist with Personal Care ☐ Promote Independence ☐ Promote Dignity and Hygiene
☐ *Other:* _____
Goals: _____

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