PRIOR AUTHORIZATION OF INCREASED STATE PLAN HOME HEALTH SERVICES

This form is to be used when requesting Prior Authorization (PA) for State Plan Home Health Services beyond the current State Plan limits. The individual must be Medicaid fee for service and may be enrolled in DODD or ODA waivers. The Provider is responsible for verifying the individual's eligibility at the date of service by viewing the client's Medicaid Card or verifying eligibility through the portal.

PLEASE ANSWER THE FOLLOWING QUESTIONS, CHECK YES IF APPLICABLE:

Is the individual **less than 21 years old?**
Yes ☐ No ☐

Does the individual require State Plan Home Health Nursing/Aide services for **14 hours or LESS per week**?
Yes ☐ No ☐

Does the individual currently use **28 hour or less per week** of **post hospital benefit?** (Up to 60 days)
Yes ☐ No ☐

Does the individual currently use **8 hours or less** of State Plan Home Health **Nursing/Aide/Therapies?**
Yes ☐ No ☐

Is the individual currently on the Ohio **Home Care or Transitional Carve-Out Waiver?**
Yes ☐ No ☐

Is the individual on a **managed care plan?**
Yes ☐ No ☐

Is the service to be used for **respite or habilitation?**
Yes ☐ No ☐

STOP **If you answer YES to any of the questions above, the request should not be submitted for Increased State Plan Home Health Services.

****PLEASE DO NOT SUBMIT THE REQUEST****

PROVIDER INFORMATION	**INDIVIDUAL INFORMATION**
Agency Name:	MMIS Number:
Address:	Recipient (patient) Name:
Provider NPI #:	Resp. Party (if applicable):
Contact Name:	Relationship:
Phone Number:	Address:
Email (for auth notice):	Email:
Fax:	Fax:
Prescribing Provider Name:	**Date Last Seen by Prescribing Provider:**
Prescribing Provider NPI #:	

Case Manager (CM)/Service Support Administrator (SSA) information (If applicable)

DODD Waivers: ☐ I/O ☐ Level 1 ☐ SELF	**ODA Waivers:** ☐ PASSPORT ☐ Assisted Living
Name:	
Phone:	
Email:	
Fax:	

Please give a complete description of the services needed. Refer to OAC 5160-12-01 (formerly 5101:3-12-01) for a list of services that will be covered under State Plan Home Health.

Services Requested:	
☐ Skilled Home Health Nursing RN (G0299)	☐ Physical Therapy (G0151)
☐ Skilled Home Health Nursing LPN (G0300)	☐ Occupational Therapy (G0152)
☐ Home Health Aide (G0156)	☐ Speech Therapy (G0153)
Hours per day/ or per week for each service type	
****If less than weekly; # of visits (1 hour=1 visit) per certification period**	
Requested Dates of Service:	
Principal Diagnosis(es) Code(s):	

I affirm all information is a true and accurate description of the above individual.

Completed by: _____

Date: _____

LACK OF CLINICAL INFORMATION DELAYS THE PROCESSING OF A PRIOR AUTHORIZATION REQUEST

Documentation Required to be Submitted:

At a minimum, the following documentation must be submitted with the request:

- ☐ Prescription or orders that are signed by the attending physician
- ☐ Complete diagnosis/es list
- ☐ Medical history
- ☐ Level of care needs based on medical necessity
- ☐ Physician certification of Medical Necessity (JFS 07137) must be included
- ☐ If the individual is on a waiver, the service plan must be included
- ☐ If currently receiving any State Plan services, please include:
  - ☐ Last 2 weeks of the visit notes
  - ☐ Current signed doctor's orders (485)
  - ☐ Nursing assessment (OASIS) completed by RN
- ☐ All documentation must be legible.
- ☐ Interventions must be consistent with State Plan Home Health rules
- ☐ Interventions must be directly related to the individual's needs and service plans (if applicable)
- ☐ Information shall be client-specific
- ☐ Information must be detailed

Please return completed form and all required documentation to Permedion by fax at 1-855-474-4306.

FOR PERMEDION USE ONLY

PA Number	Number of Visits	Number of units	Auth. Start Date	Auth. End Date	CM/SSA notified?