Medicare Advantage
Home Care Authorization Form

CareFirst Medicare Advantage

IMPORTANT

1. Claims submitted for these benefits are subject to lifetime maximums and any applicable deductibles, copayments, coinsurances or provisions, as specified in the member's contract. Benefit approval is subject to the following conditions: a) member identification number is effective at the time services are rendered, b) requested benefits are available under the member's contract.
2. Please contact the appropriate provider service area to verify member's eligibility and benefits for requested services.
3. Claim payment for approved services does not indicate payment for future services. All future claims will be evaluated in accordance with the aforementioned benefit approval conditions and the CareFirst Medicare Advantage utilization management review process.
4. If you have any questions regarding the extent of this authorization, please call 800-334-3427 ext 4402. Calls will be returned within one business day.

Participating Providers: to initiate a request and to check the status of your request, visit CareFirst Direct at **carefirst.com**.
Fax completed form to 443-753-2341.

HOME CARE RENDERING PROVIDER INFORMATION

Home Care Rendering Provider	Provider Phone #	Agency Contact Name
Home Care Rendering Provider Address	Provider Fax #	Start of Care (SOC) Date
	Provider ID #	Date of Request
	Email Address	

HOME CARE REFERRING PROVIDER INFORMATION

Home Care Referring Provider	Provider Phone #	Agency Contact Name
Home Care Referring Provider Address	Provider Fax #	Start of Care (SOC) Date
	Provider ID #	Date of Request
	Email Address	

MEMBER/PATIENT INFORMATION

Last Name	First Name	M.I.	Gender	Date of Birth
Address (Street, Apt. or Box #), City	State			Zip Code
Member Group #	Member ID # w/Prefix			
Place of Hospitalization	Hospital Admission Date			Hospital Discharge Date
Attending Physician's Name and Complete Address				
Diagnosis & Code(s) (ICD-10)	Homebound			

MEMBER/PATIENT INFORMATION

Services requested (include number of visits per day/week/month)

- ◯ Skilled Nursing (SN)
- ◯ Physical Therapy (PT)
- ◯ Nutritionist
- ◯ Speech Therapy
- ◯ Medical Social Worker (MSW)
- ◯ Home Health Aide (HHA)
- ◯ Occupational Therapy (OT)
- ◯ Private Duty Nursing (PDN) Hours per day_____

Wound Present ◯ Yes ◯ No

Location _____

*If yes; must complete

1. Measurements: _____ Length _____ Width _____ Depth
2. Measurements: _____ Length _____ Width _____ Depth

Presence of Tunneling ◯ Yes ◯ No

Drainage _____ Color _____ Odor _____ Amount

Caregiver or Member instructed in wound care
◯ Yes ◯ No

Wound Vac?
◯ Yes ◯ No

INTERNAL OFFICE USE ONLY

Authorization # and Date	SN _____ PT _____ OT _____ MSW _____ HHA _____ SLP _____ Other _____