UPHP
UPPER PENINSULA HEALTH PLAN

UPHP HOME HEALTH CARE PRIOR AUTHORIZATION FORM

*Fax completed form to **906-225-9269** as directed below.*

Date of Request: _____ Start of Care Date: _____

Check either: **Initial Authorization:** _____ **Continued Authorization:** _____

Urgency: Standard☐ Expedited/Urgent*☐
* Choose if waiting for a decision under standard timeframes would place member's life, health, or ability to regain maximum function in serious jeopardy.

UPHP Member Information

Name: _____DOB: _____

Plan Type: Advantage/Choice ☐ MI Health Link☐UPHP ID: _____

Primary Diagnosis for Home Care Services: _____
ICD-10 Codes: _____

Other/Comorbid Diagnosis: _____
ICD-10 Codes: _____

Member homebound: Yes☐ No☐ Homebound due to: _____
Location of Service: Member Home_____ Assisted Living____ Group Home_____
Assistive Devices used: _____
Other (describe):_____

Home Health Care Services Request (check all that apply)

Skilled Nursing*: ☐Reason:_____
For initial authorizations only- Were any skilled nursing visits utilized prior to authorization? If yes- enter number of visits and start date_____
Physical Therapy: ☐ Reason: _____
Occupational Therapy: ☐Reason:_____
Speech Therapy: ☐ Reason: _____
Social Services: ☐Reason:_____
Home Health Aide: ☐Reason:_____

*UPHP will cover up to 3 skilled nursing visits during the initial authorization request for home health care. Physical, Occupational, and Speech therapy evaluation and re-evaluations do not require authorization.

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Home Care Agency Information

Agency Name: _____ NPI: _____

Address: _____ City, State, Zip: _____

Contact Name: _____

Contact Phone: _____ Contact Fax: _____

MD/Ordering Provider Information

Name: _____ NPI: _____

Practice Name: _____

Practice Address: _____ City, State, Zip_____

Phone: _____ Fax: _____

Date of last appointment: _____ Next visit date (If known): _____

UPHP Staff Use Only

Member Name_____ Member Date of Birth_____

Determination: Approved____☐____ Denied____☐____ Decision Date:_____

UPHP Staff:_____ UPHP Authorization #:_____

Skilled Nursing R0551: # Visits: _____Duration:_____ to _____

Physical Therapy R0421: # Visits: _____Duration:_____ to _____

Occupational Therapy R0430: # Visits: _____Duration:_____ to _____

Speech Therapy R0441: # Visits: _____Duration:_____ to _____

Social Services R0561: # Visits: _____Duration:_____ to _____

Home Health Aide R0571: # Visits: _____Duration:_____ to _____

Authorization does not guarantee payment.
All referrals are subject to review for medical necessity, member eligibility, and plan benefits at the time of service.