



**BlueCross BlueShield
of Tennessee**

P.O. Box 180205
Chattanooga, TN 37402

www.bcbst.com

THIS INFORMATION IS CONFIDENTIAL

**BlueAdvantage
Home Health Services
Prior Authorization Form**

1. Prior Authorization is required prior to and/or no later than 24 hours or one business day after services have been started. The prior authorization form must be completed and faxed to 1-800-255-0244.
2. **Extensions:** Prior authorization must be requested for continuation of services beyond previously approved dates.
3. When requesting approval for additional services beyond the dates previously approved, the specific services, dates of services, physicians orders and nurses notes must be faxed along with the request for additional services

TYPE or PRINT

TO BE COMPLETED BY HOME HEALTH PROVIDER

Member Information:

Member Name: _____ Sex: M _____ F _____

Telephone Number : (____) _____ Date of Birth: _____

Complete Address: _____

Is patient covered by other health insurance? Yes ___ No ___ If Yes, Insured's Name: _____

Other insurance policy or certificate number: _____

Physician or Supplier Information:

Member's Diagnosis: _____

Date of Diagnosis: _____ Date of Last Treatment: _____

Prognosis: _____

Physician's Name: _____

Complete Address: _____

Telephone Number:(____) _____

Home Health Agency Name: _____

Home Health Agency Complete Address: _____

Telephone Number:(____) _____ Fax Number: (____) _____

Name of Contact Person: _____

ACTIVITY

Activity / Limitations: _____

Homebound: Yes _____ No _____ If Yes, explain: _____

Does the patient live alone? Yes _____ No _____ If No, how much care can be given by the caregiver?

Member Name: _____ ID Number: _____



**BlueCross BlueShield
of Tennessee**

P.O. Box 180205
Chattanooga, TN 37402

www.bcbst.com

I. Dates of service Home Health Services requested: _____
From: (Start) _____ Thru: (End) _____
SNV _____ PT/ST/OT _____ Other _____
Frequency Hours per day Days per week

Treatment: _____

Extensions

The following checked information is needed on the next update before an extension will be considered:

- _____ Is patient still homebound? Why
- _____ Lab results/change in treatment
- _____ Nursing notes
- _____ Description and/or photo of wound
- _____ Has patient/caregiver been trained? If not, why not?
- _____ Physician's orders
- _____ Date of next MD appointment
- _____ Change of orders since last MD appointment

II. Dates of service Home Health services requested:
From: (Start) _____ Thru: (End) _____
SNV _____ PT/ST/OT _____ Other _____
Frequency Hrs per day Days per week

Treatment: _____

Extensions

The following checked information is needed on the next update before an extension will be considered:

- _____ Is patient still homebound? Why
- _____ Lab results/change in treatment
- _____ Nursing notes
- _____ Description and/or photo of wound
- _____ Has patient/caregiver been trained? If not, why not?
- _____ Physician's orders
- _____ Date of next MD appointment
- _____ Change of orders since last MD appointment