

## Home Health Care Request Form

**Save time and use PHP's EZ auth portal to submit authorizations, click here: [HealthTrio Connect - PHP](#)**

*instructions:* All sections must be completely filled out for review.

Please fax the completed form and relevant chart notes to 517.364.8409 Monday - Friday, 8 a.m. to 5 p.m. EST, except holidays

Patient Information		Prescriber Information	
Today's date:	Referring Provider's name:		
Member name:	Office phone:	Fax:	
Member's PHP ID#:	Office contact:		
Date of birth:	Patient's Primary Physician:		
Treatment/Request Information			
<input type="checkbox"/> New Request <input type="checkbox"/> Extension, authorization # _____			
ICD9/10 Diagnosis code:		Anticipated start of care date:	
Visit type: <input type="checkbox"/> SN      Number of Visits Requested: _____      Dates of service: from _____ to _____ <input type="checkbox"/> PT      Number of Visits Requested: _____      Dates of service: from _____ to _____ <input type="checkbox"/> OT      Number of Visits Requested: _____      Dates of service: from _____ to _____ <input type="checkbox"/> ST      Number of Visits Requested: _____      Dates of service: from _____ to _____ <input type="checkbox"/> SW      Number of Visits Requested: _____      Dates of service: from _____ to _____ <input type="checkbox"/> Aide    Number of Visits Requested: _____      Dates of service: from _____ to _____			
Home Health Contact Person & Title:		Agency: <i>(include address, city, state, zip)</i>	
Provider TIN and NPI:		Phone:	Fax:
Description of skilled services <i>(e.g. SNV dressing changes daily for wound, IV therapy – drug/dose/frequency, PT for gait training, OT for upper body strength)</i>			