MEDICAL MUTUAL®

Medicare Advantage Home Healthcare Request Form

This form is imaged and may be filled in using Acrobat Reader. Please use a separate form for each patient, complete all sections and attach supporting documentation. Fax the completed form to 1800-221-2640.

Prior approval is required for skilled nursing, physical therapy, occupational therapy, speech therapy and home health aide services after 120 days from the start of care date.

Supporting documentation must include:

- Plan of Care or OASIS
- Notes from the last two visits for each discipline requested
- Member/caregiver responses to interventions, teaching and training
- Discharge planning and estimated remaining home care duration for each discipline

PROVIDER AGENCY INFORMATION		
Agency Name*		Agency Phone Number*
NPI Number	TIN*	Agency Fax Number*
Address (street, city, state & zip) location of agency requesting service*		
Contact Name*		Contact Phone Number*

PATIENT INFORMATION	
Patient Name (last, first, middle initial)*	Insurance Identification Number*
Patient DOB*	Patient Phone Number*
Ordering physician full name*	Ordering physician phone number*
Ordering physician address*	

SERVICE REQUEST		**From**	**To**
Total service requests are limited to 60-day episodes.			
☐ Start of Care Date: _____			
☐ Skilled Nursing	No. Visits Requested: _____		
☐ Physical Therapy	No. Visits Requested: _____		
☐ Occupational Therapy	No. Visits Requested: _____		
☐ Speech Therapy	No. Visits Requested: _____		
☐ Home Health Aide	No. Visits Requested: _____		