BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

HOME HEALTH SERVICES PRECERTIFICATION REQUEST FORM

Please note: *A review cannot be completed without adequate clinical documentation.* ***Print legibly****.*

I. Patient Information

Name	Date of Birth
Contract Number (include prefix)	Group Number

II. Ordering Provider Information

Name		National Provider Identifier (NPI)	
Address			
City		State	Zip
Office Telephone	Fax Number	Email	

III. Home Health Agency Information

Name			
Address			
City		State	Zip
Office Telephone	Fax Number	Email	

IV. Admission Information

Primary Diagnosis Code *(Do not use "V" codes)*	Secondary Diagnosis Code *(Do not use "V" codes)*

Patient's Skilled Nursing Needs: *Check all that apply.*

☐ Assessment ☐ Feeding Tube ☐ Foley Catheter ☐ IV Therapy/VAD ☐ Ostomy ☐ Teaching

☐ Wound Care *(Must include current measurements, drainage and orders)*

☐ Other _____ Description: _____

Skilled Nursing Care Initial Start Date		Date last approved visit was used *(if this request is for ongoing care)*	
Number of visits for this request	Start Date for this request	Frequency of visits	End Date

Does this request include physical/occupational/speech therapy/other home health discipline? ☐ Yes ☐ No

If yes, check all that apply:

☐ Home Health Aide (Fax to: 205-733-7374 or 1-888-295-3005) ☐ Occupational Therapy (Fax to: 205-402-9369) ☐ Physical Therapy (Fax to: 205-220-0941)

☐ Social Worker (Fax to: 205-733-7374 or 1-888-295-3005) ☐ Speech Therapy (Fax to: 205-402-5708)

☐ Other _____ Description: _____

Reminder: *Adequate clinical documentation in support of your request MUST be included to avoid delays.*

V. Certification Section

Printed Name	Signature	Date Signed

Check eligibility and benefits online prior to submitting precertification request. Not all contracts require precertification. Contact Provider Customer Service at 1-855-288-8357 if you have questions.