Care Direct
Health Resources

Prior Authorization Request
Home Health Services

Valid and appropriate clinical documentation must be attached to complete this referral.

Home Health Agency

Agency Name:

Agency Location (City):

Form Completed by:

Agency Phone Number:

Agency Fax Number:

Patient

Patient Name:

Date of Birth:

Address:

Insurance

Primary Insurance Provider:

Policy Number:

Following Physician

Following Physician Name:

Service(s)

Diagnosis Codes (ICD-10):

Start of Care Date:

HCPCS/CPT/Procedure Code(s) Requested:

Type of Request

SOC: ☐ Extension Request: ☐ ROC: ☐ Recert: ☐

Number of Visits Being Requested

SN: PT: OT: HHA: ST: MSW:

Notes:

Valid and appropriate clinical documentation must be attached to complete this referral.
Return completed form by fax to (608) 664-6193 OR by email to chrfax@uwhealthcaredirect.com.