

Home Health Visit and/or Home Therapy Services

DOC TYPE 5V

RMHP Statewide Fax: 877-201-7302 or 970-254-5738

WINhealth Partners Fax: 877-825-3018

Date Request Submitted: _____

New Request Revised Request — Original Reference # _____

Patient Name: _____ DOB: _____

RMHP ID Number: _____

Line of Business: Medicaid CHP+ Commercial Medicare (Home Infusion only)

Service Provider: _____ Phone: _____

Contact: _____ Fax: _____

Referring Physician: _____

ICD9 Code: _____ Diagnosis: _____

Patient Care Needs: Please Attach Physician's Orders and Plan of Care

IV Orders:

IV Supplier:

Start of Care Date:

End Date:

Continuation of Care Date:

Revised End Date:

Services Requested Per Plan of Care

RN:	FHHO
Aide:	FHAO
MSW:	FHSO
PT:	FPTO
OT:	FOCO
ST:	FSLO

The preauthorization for services noted in this form is only for the time period during which the patient remains eligible on the patient's current health benefit plan or for a shorter period as specified in this form. Rocky Mountain Health Plans is not financially responsible for the services that are preauthorized if the patient is not eligible on the date services are provided. Further as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness or efficacy, and coverage for services being provided and is subject to the terms and conditions in the Member's Evidence of Coverage, including but not limited to, coordination of benefit provisions, preexisting conditions and limitations, and any agreements between Rocky Mountain Health Plans and the health care provider. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and paying health services as used by Rocky Mountain Health Plans.

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