Washington State Health Care Authority

Home Health Authorization Request*

This is confidential information intended only for the person to whom it is faxed. Please return this form by Online direct data entry (hca.wa.gov/billers-providers-partners/prior-authorization-claims-andbilling/prior-authorization-pa) or fax this form along with the General Information for Authorization (GIA) form (13-835) to Authorization Services at 1-866-668-1214. The GIA form must be page one of your fax (no fax coversheet)

1 General information

Contact name ______________________ Agency name ______________________

Provider NPI __________ Phone number __________ Fax number __________ Clinical contact __________

Client name ______________________ ProviderOne client ID ______________________

DSHS (social worker or nurse) case manager (if known) __________ Phone number __________ Fax number __________

Type of request: Limitation extension

Prior authorization required for clients with AEM coverage (only two visits allowed if authorized)

2 Additional therapy request information

PT – Number of units requested: __________ Number of units used: __________
(1 unit = 15 minutes)

OT – Number of units requested: __________ Number of units used: __________
(1 unit = 15 minutes)

ST – Number of units requested: __________ Number of units used: __________
(1 unit = 1 visit, no matter the length of the visit)

SW – Number of units requested: __________ Number of units used: __________
(1 unit = 15 minutes)

Home Health - related diagnosis(es) ______________________

ICD Dx: __________ Description ______________________

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What is the reason that Home Health is needed, or why does it not meet Home Health program criteria?
For clients with AEM coverage, how is this related to the emergency condition?

What is the client-specific medical justification (or reason for this request) and what services will be provided?

For Home Health, why is this client not able to access the skilled care needed in the community?

For Home Health, what is the estimated time that the client will receive services?

***The plan of care (including provider orders) must be attached to this request.**