Authorization Request

Home Healthcare/Hospice

Utilization Review Department
Michigan Conference of Teamsters Welfare Fund
Phone: (313) 964-2400

Please fax back this completed form for your authorization request with the supporting medical records (Continuing Patient Care [CPC] form, home healthcare provider referral form, certification and plan of care, hospital discharge summary or physician referral) to: (313) 496-2939

Today's Date: _____

Patient's Name: _____

Contract #: _____

Date of Birth: _____

Discharging Hospital: _____

Duration of Stay Admit: _____Discharge: _____

Is the patient Immobile? Yes: _____ No: _____

If no, please explain why HHC services are needed: _____

_____

Start of Care Date:

_____

Length of Care Request (From & To): _____

Services Being Requested:

Skilled Nursing: Procedure code: _____ Number of Visits: _____

Physical Therapy: Procedure code: _____ Number of Visits: _____

Occupational Therapy: Procedure code: _____ Number of Visits: _____

Social Worker: Procedure code: _____ Number of Visits: _____

Speech Therapy: Procedure code: _____ Number of Visits: _____

Diagnosis Code (s): _____

Clinician Signature: _____

Provider/Facility Name: _____

Address: _____

Contact Person: _____

Phone: _____ Fax: _____