



of Tennessee

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801 Pine Street
Chattanooga, TN 37402

bcbst.com

THIS INFORMATION IS CONFIDENTIAL

**BlueAdvantage
Home Health Services
Advance Determination Form**

1. Advance Determination is recommended for all Home Health Services. However, you may complete one evaluation visit prior to requesting a review. This Advance Determination form should be completed and faxed to 1-888-535-5243.
2. Please submit the completed OASIS form along with this request, specifying the certification period being requested.
3. Extensions: Advance Determinations are recommended for continuation of services beyond previously approved dates.
4. When requesting Advance Determination for additional services beyond the dates previously approved, the specific services, dates of services, physician's orders and nurse's notes must be faxed along with the request for additional services two (2) days prior to the end of services. You must issue the Notification of Medicare Non-Coverage (NOMNC) to the member and fax a copy for our records to 1-888-535-5243 if the extension is not approved.

TYPE OR PRINT

TO BE COMPLETED BY HOME HEALTH PROVIDER

Member Information

Member Name: _____ Sex: M _____ F _____
 Telephone Number: (____) _____ Date of Birth: _____
 Complete Address: _____
 Is patient covered by other health insurance? Yes ___ No ___ If Yes, Insured's Name: _____
 Other insurance policy or certificate number: _____

Physician or Supplier Information

Member Diagnosis: _____
 Date of Diagnosis: _____ Date of Last Treatment: _____
 Prognosis: _____
 Physician Name: _____
 Complete Address: _____
 Telephone Number: (____) _____
 Home Health Agency Name: _____
 Complete Address: _____
 Telephone Number: (____) _____ Fax Number (____) _____
 Contact Person: _____

Activity

Activity/Limitations: _____
 Homebound: Yes ___ No ___ If Yes, explain: _____
 Does patient live alone? Yes ___ No ___ If No, how much care can be given by the caregiver? _____



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P.O. Box 180205
Chattanooga, TN 37402

bcbst-medicare.com

Member Name: _____ Member ID
Number: _____

I. Dates of requested Home Health Services: _____
From: _____ Through: _____
SNV _____ PT/ST/OT _____ Other _____
Frequency Hours per day Days per week

Treatment: _____

Extensions

The following checked information is needed on the next update before an extension will be considered:

- _____ Is patient still homebound? Why?
- _____ Lab results/change in treatment
- _____ Nursing notes
- _____ Description and/or photo of wound
- _____ Has patient/caregiver been trained? If no, why not?
- _____ Physician's orders
- _____ Date of next doctor appointment
- _____ Change of orders since last doctor appointment

II. Dates of requested Home Health services:
From: _____ Through: _____
SNV _____ PT/ST/OT _____ Other _____
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