



801 Pine Street
Chattanooga, Tennessee 37402-2555

vshptn.com



Private Duty / Skilled Nurse Visit Home Health Aide Request Form

Initial Request or Extension of Services

Prior Authorization is required prior to scheduled services being rendered or within 24 hours or the next business day for emergency services. Call the UM pre-service line or complete this form and fax to:

BlueCare/TennCareSelect
Phone: 1-800-924-7141
Fax Number: 1-800-292-5311

When Prior Authorization / Notification is required and services are needed beyond the number of services authorized by Volunteer State Health Plan, Inc., you must request that the services be extended prior to the end date of the initial Prior Authorization date.

To be completed by Physician

(Circle requested service and indicate the specific duration of the requested service i.e. 24/7, 12/7 etc.)

Home Health Aide	Duration _____	Skilled Intermittent Nurse Visits	Duration _____	Private Duty	Duration _____
------------------	----------------	-----------------------------------	----------------	--------------	----------------

Member Information		
Member Name (First, Middle, Last):	Member ID Number:	Member Date of Birth:
Member Address (Street, City, State, Zip)	Gender: Female <input type="checkbox"/> Male <input type="checkbox"/>	Diagnosis Code

Provider and Supplier Information		
Physician Name:	Phone Number:	Fax Number:
Provider Number:	National Provider Identifier:	Tennessee Medicaid Number:

Original Start Date of Care: _____	Dates of Service for this Reference From: _____ To: _____
------------------------------------	---

The following information is needed when requesting approval of new requests and to extend existing services (Please provide this information to us within 24 hours of receipt of this form):

<p>Type of Care Needed: (What is the specific hands on care (SKILL) the member needs to treat his/her problem that the aide or nurse will do for the time he/she is in the home? What is the frequency or type for this care, i.e., twice a day, every six hours? Keep in mind housekeeping, laundry services, caregiver, monitoring or preparation of meals are not covered per new TennCare Guidelines. Behavioral Health services for BlueCare and TennCareSelect members are coordinated through VSHP.</p> <ul style="list-style-type: none"> ▪ Please attach any supporting documentation <p style="text-align: center;">Home Health Aide (When skilled nursing criteria is met, the nurse will provide Home Aide services) (Skill) (Frequency or Type)</p>	
<input type="checkbox"/> Bath	
<input type="checkbox"/> ADL's	
<input type="checkbox"/> Hand Patient Medications	
<input type="checkbox"/> Patient Transfers	
<input type="checkbox"/> Vital Signs	
<input type="checkbox"/> Other – Please Specify	

Skilled Nurse Visit	
(Skill)	(Frequency, Type, Time Needed to Perform Skill)
<input type="checkbox"/> Suction	
<input type="checkbox"/> Bolus Tube Feedings	
<input type="checkbox"/> IV and/or IM Medications	
<input type="checkbox"/> Venipunctures	
<input type="checkbox"/> Injections	
<input type="checkbox"/> Intravenous Feedings	
<input type="checkbox"/> Insertion and sterile irrigation of catheters/Catheters Care	
<input type="checkbox"/> Application of dressings (wound care) involving prescription medications and aseptic techniques	
<input type="checkbox"/> Treatment of extensive decubitus ulcers or other widespread skin disorders	
<input type="checkbox"/> Other – Please Specify	

Private Duty Nursing Services (PDN) – 8 hours or more	
(Skill)	(Frequency or Type and Number of Hours)
<input type="checkbox"/> Continuous Intravenous Therapy or TPN	
<input type="checkbox"/> Continuous Gastrostomy Feedings (include the time needed to begin, disconnect and flush - not the entire time the feeding is dispensing)	
<input type="checkbox"/> Nasopharyngeal and Tracheostomy Care - Stoma care, suctioning, humidification, changing a tracheostomy tube, and emergency procedures for tracheostomy care	
<input type="checkbox"/> Monitor of ventilators – Positive pressure or negative pressure ventilation	
<input type="checkbox"/> Other respiratory therapies – Nebulizer, Chest PT	
<input type="checkbox"/> Other – Please Specify	

Is there a trained family member or friend available as caregiver in the home? Yes No
 Number of hours per day: _____ Reference number if request is for extension of services: _____

- Note – A request cannot exceed a maximum of eight (8) weeks in duration

This form is to be used for additional information and will work in conjunction with the CMS-485 and is not to be used as an order unless signed and specified below. This approval is subject to verification of all medical information and is valid only if such information is accurate and complete. Payment of benefits remains subject to all contract terms, conditions and exclusions and to the patient's eligibility for benefits at the time expenses are incurred.

Additional Information: Physician's Order:

Date of Request: _____ Physician's Signature: _____ Date: _____