

### Nebraska Home Health Prior Authorization Request Form

- Fee For Service (Telligen) Fax: 1-855-638-8017       Nebraska Total Care Fax: 1-844-774-2363  
 UnitedHealthCare Fax: 1-866-622-1428       HealthyBlue Fax: 1-844-886-2754

#### REQUEST TYPE

- Initial Request       Continuation of Services  
 Standard Request       Expedited Request

#### MEMBER INFORMATION

Medicaid ID \_\_\_\_\_ MCO Member ID \_\_\_\_\_  
Member Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Member Phone Number \_\_\_\_\_

#### REQUESTING PROVIDER INFORMATION

Medicaid/MCO Provider # \_\_\_\_\_ OR NPI # \_\_\_\_\_  
Ordering Provider \_\_\_\_\_ Provider address with zip +4 \_\_\_\_\_  
Ordering Provider Contact \_\_\_\_\_ Date of Face to Face \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

#### SERVICING PROVIDER Same as Requesting Provider

Medicaid/MCO Provider # \_\_\_\_\_ OR NPI # \_\_\_\_\_  
Servicing Provider \_\_\_\_\_ Provider address with zip +4 \_\_\_\_\_  
Servicing Provider Contact \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

#### SERVICE REQUESTED

Start Date \_\_\_\_\_ End Date \_\_\_\_\_ Original Start of Care Date \_\_\_\_\_

ICD-10 Code \_\_\_\_\_ Diagnosis Description \_\_\_\_\_

Primary Procedure Code \_\_\_\_\_ Modifier \_\_\_\_\_  Units \_\_\_\_\_  Visit \_\_\_\_\_  Days \_\_\_\_\_

Additional Procedure Code \_\_\_\_\_ Modifier \_\_\_\_\_  Units \_\_\_\_\_  Visit \_\_\_\_\_  Days \_\_\_\_\_

Additional Procedure Code \_\_\_\_\_ Modifier \_\_\_\_\_  Units \_\_\_\_\_  Visit \_\_\_\_\_  Days \_\_\_\_\_

Additional Procedure Code \_\_\_\_\_ Modifier \_\_\_\_\_  Units \_\_\_\_\_  Visit \_\_\_\_\_  Days \_\_\_\_\_

**PLEASE ATTACH CLINICAL DOCUMENTATION SUCH AS PLAN OF CARE, MEDICAL RECORDS, PROGRESS NOTES, TEST RESULTS, TREATMENT RENDERED AND RADIOLOGY REPORTS FROM LAST 3 MONTHS PERTINENT TO REQUESTED SERVICE**

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Medicaid/Plan policy and procedures.

*A form from the Nebraska Department of Health and Human Services.*

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