Metro Plus Health

HOME CARE SERVICES REQUEST FORM

Please fax this form along with supporting clinical documentation to 212-908-3730. For general questions call 800-303-9626.

Authorization/Tracking #:	**E-Power Cert #:** (if applicable)

REQUEST TYPE		
☐ **Preauthorization:** New request for services not previously approved, prior to service date	☐ **Concurrent:** Request for additional services for a service previously approved (ongoing care)	☐ **Retrospective:** Request for services already rendered without prior authorization
☐ **Standard** • Preauthorization = 3 business days • Concurrent = 1 business day • Retrospective = 30 calendar days	☐ **Expedited:** The expedited review request is subject to denial if there is no documented life-threatening condition or imminent danger to the member's health. If a request to expedite a review is denied, a determination will be made within the standard timeframe. Retrospective reviews are not eligible for expedited review.	

MEMBER INFORMATION		
Name:	ID#:	Date of Birth:
Street Address:		
ICD-10 Diagnosis Codes(s):		

PROVIDER INFORMATION		
Name:	ID#/TIN/NPI:	
Street Address:		
Phone Number:	Fax Number:	Contact Name:

REQUESTED SERVICE INFORMATION

Service	CPT/HCPCS/Service Codes	Start Date	End Date	# of visits/units/ hours	POS 10= Telehealth provided in the Home 12= Home (in person)
Skilled Nursing					
Physical Therapy					
Occupational Therapy					
Speech Therapy					
Respiratory Therapy					
Nutritional Therapy					
Social Work Services					
Home Health Aide					
Home MD Visits					
Home Infusion Services					
Private Duty Nursing	S9124 (No less than 75% of total hours)				
Private Duty Nursing	S9123 (No more than 25% of total hours and must submit justification for higher level of care)				