

Home Health Care Visit Request Form

| | |
|-------------------------------------|----------------|
| From _____ | Phone _____ |
| Reference number _____ | Fax _____ |
| Pages (including cover sheet) _____ | Comments _____ |

Please ensure that all the following information is included. Please upload all clinical information to the NYCE PPO portal at nyceppo.com.

| | |
|-------------------------|---------------------|
| Patient full name _____ | Date of birth _____ |
| Member ID _____ | MM/DD/YYYY |

Required documentation:

- Up-to-date clinical information/assessment/wound measurements
- MD order
- Homebound status
- Ordering MD name, address, phone

For each requested home health care (HHC) service, please indicate the following:

- HHC service and code(s) being requested (SNV, PT, OT, ST)
- Start date of current request (for additional visits, please put the new/concurrent start date, not the date of initial request)
- Number of visits being requested
- Number of visits previously used

HHC service requested and CPT Code _____

Start date of current request _____

Number of visits being requested _____

Number of visits previously used _____