ClinicalSpecialties
an Option Care owned company

Home Health Service Authorization

Authorized Home Health Provider

Kindred At Home Newark
675 Hopewell Drive
HEATH, OH 43056
Phone: (740) 522-6017 Fax: (740) 522-5339

CSI Contact Information

Authorization
Phone (440)717-1700/(888)873-7888 - Option #3
Fax (440)717-1705, (866)717-1722

Patient: P77532

Fellows, Lee
Female, Age 62, Born 10/6/1954
138-52-7942

Patient Home & Service Address

242 Glyntawel Dr
GRANVILLE, OH 430231522
Phone: (740) 321-1472

Authorization for services IS NOT a guarantee of payment. Payment for all services authorized or listed as not requiring pre-authorization is subject to insurance rules, medical necessity, and prior agreements with CSI.

Please notify CSI IMMEDIATELY of any changes to the patient's insurance, responsible parties, guarantors, or clinical status that may affect eligibility or reimbursement for services performed.

Authorized Home Health Service (NOT a Guarantee of Payment)	From - To	Billing Code	Auth #	Visits/ Days
CSI IV Nurs(to 2hrs)	2/1/2017 - 4/1/2017	99601	2723008	10 Visit(s)

Patient Insurance Information (all information subject to change at any time)

Payer Name	Policy #	Deductible	Annual OOP Max	Maximum Lifetime Benefit	Medicare/ Medicaid HMO Status
Anthem : ANTHEM BC\BS	NURAN3279123	$0.00	$7,200.00	$0.00	

2017 BENEFITS::ANTHEM PPO::HOME HEALTH/HOME INFUSION COVERAGE AT 67% NO DED.::ONCE OOP IS MET, COVERAGE AT 100%.::OOP HAS NOTHING APPLIED.::SERVICES ARE BASED ON MEDICAL NECESSITY.::HOME HEALTH BENEFITS INCLUDE SN/PT/OT/ST/MSW/HHA.::CUSTODIAL CARE IS NOT COVERED.::HOME HEALTH/HOME INFUSION VISITS BASED ON MEDICAL NECESSITY.::CALENDAR YR PLAN. ::

Contact CSI at:

Referral line: 888.873.7888
Main line: 888.873.8999
Local line: 440.717.1700

- To initiate ANY new referral (Home Health, Home Infusion or Hospice) Press 1
- Eligibility and Authorizations for a new patient Press 2
- Authorization department Press 3
- Pharmacy calls regarding supplies, a delivery or to speak with a pharmacist Press 4
- Patient calls to make a payment or for questions on your bill or insurance Press 5
- Provider questions on claims Press 6
- Provider questions on your CSI contract, or to become a participating provider Press 7
- Access Company Directory Press #
- Repeat Options Press 9

Provider Request Form

Date of Request: _____ Phone: _____

Agency Name: _____ Fax: _____

Contact Name: _____

Patient Information:

Name: _____ Date of Birth: _____

Payer: _____

Services Requested:

DATE RANGE: _____

	# of Visits		# of Visits
☐ Skilled Nursing RN	_____	☐ IV Nursing (Up to 2 hrs)	_____
☐ Skilled Nursing LPN	_____	☐ IV Nursing (>2 hrs)	_____
☐ Physical Therapy	_____	☐ Occupational Ther.	_____
☐ Speech Therapy	_____	☐ Home Health Aide	_____
☐ Medical Soc. Worker	_____	☐ Hospice (# of Days):	_____
☐ Private Duty Nursing:		☐ Routine: _____ ☐ Continuous: _____	
Hours/Day_____ # of Days:	_____	☐ Inpatient: _____ ☐ Respite:	_____

Documentation Required

1. **PAYERS REQUIRING CLINICAL DOCUMENTATION PRIOR TO AUTHORIZATION OF SERVICES:**
   a. **Humana**
   b. **Medical Mutual of Ohio – Physical Therapy, Speech Therapy, Occupational Therapy, Home Health Aide**
   c. **The Health Plan (Hometown)**
   d. **United HealthCare**
   e. **Out of state BC/BS plans**

2. **ALL OTHER PAYERS:**
   CSI will contact your office for any additional information as requested by the Payer.

AUTHORIZATION QUESTIONS PLEASE CALL 888.873.7888 OPTION #3.