Provider Request Form

For authorizations and eligibility

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	_____	☐ Skilled Nursing LPN	_____
☐ Physical Therapy	_____	☐ Occupational Therapy	_____
☐ Speech Therapy	_____	☐ Home Health Aide	_____
☐ Medical Soc. Worker	_____	☐ Hospice (# of Days):	
☐ Private Duty Nursing:		☐ Routine: _____ ☐ Continuous:_____	
Hours/Day_____ # of Days: _____		☐ Inpatient: _____ ☐ Respite: _____	

Documentation Required – please NOTE that payer documentation requirements may change, refer to our portal or review our authorization guides

1. **PAYERS REQUIRING CLINICAL DOCUMENTATION PRIOR TO AUTHORIZATION OF SERVICES:**
   a. **Medical Mutual of Ohio – Skilled Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, Home Health Aide**
   b. **The Health Plan (Hometown)**
   c. **United HealthCare**
   d. **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 440.717.1700 OPTION #3, Option #2

Billing and Reimbursement Questions please email agencyclaims@optioncare.com