



**PHYSICIAN REQUEST
FOR HOME HEALTH CARE SERVICES**

Date of Request: _____

REQUESTING PHYSICIAN INFORMATION	
Name:	Provider ID #:
Address:	
Phone: ()	Fax: ()
Contact Person/Title:	

AvMed MEMBER INFORMATION	
Names - Last, First	
AvMed ID #: A	Date of Birth:
AvMed Case Manager (circle choice): YES / NO / UNKNOWN	
Name of AvMed Case Manager:	

HOME HEALTH AGENCY INFORMATION	
Home Health Agency:	Provider ID #:
Contact Person:	Phone: () Fax #:
Address:	

INITIAL EPISODE PERIOD: <input type="checkbox"/>	-OR-	SUBSEQUENT EPISODE PERIOD: <input type="checkbox"/>
EPISODE PERIOD DATES: From: _____ / To: _____		

Type of Service	# Visits/Week	# Weeks	# Hrs/Day (HHA only)*
RN:			
LPN:			
PT:			
OT:			
Speech:			
MSW:			
HHA*:			

Indicate summary of clinical data justifying the requirement of "Reasonable & Necessary" status:

**PHYSICIAN REQUEST
FOR HOME HEALTH CARE SERVICES**

AvMed Member Name: _____ ID #: A _____

Date of Request: _____

TREATMENT REQUEST BASED ON PLAN OF CARE	
Service Type	Type of Care to be Rendered:
RN:	
PT:	
LPN:	
OT:	
Speech/Lang:	
MSW:	
HHA:	

COMMENTS: _____

MY SIGNATURE BELOW ATTESTS TO THE FOLLOWING:
<ul style="list-style-type: none"> • The services are “reasonable and necessary” as supported by accompanying clinical documentation; • Member is “confined to home”; • Service is requested on an “intermittent/part-time” basis; • Home Health Aide services will be rendered <i>in correlation with and during the same time frame as professional services.</i>

Physician’s Signature: _____

Date: _____