

Home Health Care Worksheet

Attn: HHC Coordinator

Toll Free Phone Number: 1-800-891-2520

Fax: 567-661-0843

Date of Request: _____

Member Name: _____ Date of Birth: _____

Paramount ID #: _____ Paramount Secondary ID#: _____

Agency Name: _____

Agency Contact Name & Phone #: _____

Agency NPI: _____

Agency Fax: _____

Authorization #: _____ Current Auth # Start Date: _____

Paramount requires documentation that supports your request for further visits. Please check off the boxes before sending to ensure no delay in your request.

- Current 485 (Physician Signature required for requests for Hourly HHA and PDN)
- Nursing SOC OASIS or Other Admission Assessment (initial request only)
- Therapy/SN clinical from at least 2 visits
- Hourly HHA-time sheets
- Paramount Review Worksheet completed thoroughly

VISIT AUTHORIZATION

If billing PDGM, check the appropriate boxes below for column 1 and complete column 3.

Discipline	1. # Visits completed since current auth # Start Date	2. Additional visits requested through end of cert period	3. Date you're requesting your visits through	4. Total number of visits (Completed+Requested)
PDN				
SN				
PT				
OT				
ST				
HHA				
MSW				

Failure to send all required documentation, by the date specified, may impact your payment for services at no penalty to the member.

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