HealthPartners

Mailing Address: P.O. Box 1309 Minneapolis, MN 55440-1309 **Fax number**: 952-853-8830

Continued In-home Treatment Prior Authorization Request Form

HealthPartners CANNOT accept a completed form via e-mail. Can only accept via fax or US mail.

Name of Member to Receive Services:	**Member's Insurance ID #:**	**Member's DOB:**

Provider Name / Degree/ License	**Phone #:**	**Fax #:**
Address:	**Tax ID #:**	**NPI #:**
Is provider Supervised? _____ Yes _____ No **Are you a Rule 29 clinic? _____ Yes _____ No**	**Supervisor / Degree/ License**	

Do not use this form if care is provided in the office and NOT the home.

Is this care still being provided in the home?

If yes, why does care need to continue in the home and not in the office?

If yes, when will the member be ready to transition care to the office?

Circle codes requested: 90834 90837 90846 90847 90853	**Requested Start Date:**

Current and Provisional ICD-10 Diagnosis (es)

Current symptoms for each diagnosis with frequency/intensity AND Progress on symptoms since last authorization:
(E.g. Difficulty sleeping – was averaging 4-5 hrs 7/7 nights and is now sleeping 6 hrs a night 4/7 nights x 2 wks)

Current measurable goals with how you are measuring them AND Progress on treatment goals since last authorization:
(E.g. Goal 1: Decrease depr as reflected by a Beck Depr Inventory score of 10 or less. Last review was a 19 and now is at a 13 x 2 wks)

How will you know that the member is ready to terminate treatment? (E.g. BDI of 10 or less for 3 months)

Medication changes and dates:

Estimated termination date:

Form completed by: **Date:** **Phone #:**

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