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**BlueCross BlueShield  
of Mississippi**

## HOME HEALTH EVALUATION REQUEST

Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ BCBSMS Provider ID#: \_\_\_\_\_

Location: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Contact Fax #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ BCBSMS ID#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Patient Phone #: \_\_\_\_\_

Other Coverage:  Medicare  Medicaid  Private Ins. \_\_\_\_\_

Caregiver: \_\_\_\_\_ Ordering MD: \_\_\_\_\_

MD Phone #: \_\_\_\_\_ MD Fax #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Procedures: \_\_\_\_\_

Is this episode of care related to an accident or work related injury:  Yes  No

MD Orders: \_\_\_\_\_

DME & Supplies: \_\_\_\_\_

Has the patient had a recent hospitalization?:  Yes  No

Hospital Name: \_\_\_\_\_ D/C Date: \_\_\_\_\_

Skill/Disciplines Requested:  SN  HHA  PT  OT  ST  SW  Other \_\_\_\_\_

Expected HH Admit Date: \_\_\_\_\_ Homebound Indicators: \_\_\_\_\_

Prior authorization/Precertification is a determination of medical necessity. It is not a guarantee of payment or that the member's contract will be in effect at the time services are rendered.

DO NOT WRITE BELOW THIS LINE

Initial Eval: \_\_\_\_\_ Auth #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax initial evaluation/assessment and treatment plan for approval of additional visits to 1-800-348-3804. If you need to speak with a CM Intake Coordinator, please call 1-800-841-9659, extension 4009.