



An independent licensee of the Blue Cross® and Blue Shield® Association serving residents and businesses of Minnesota

Home Health Pre-Service Request Date:

Provider Information

Servicing Provider		Ordering Provider	
Name:		Name:	
Provider #:		NPI:	
Street Address:		Street Address:	
City:		City:	
State:	Zip:	State:	Zip:
Phone:	Fax:	Phone:	Fax:
Contact Name/Phone: /		Contact Name/Phone: /	

Medicare certified agency: yes no (other certification) _____

Patient Information

Patient Name:	Subscriber Name:
DOB:	Group #:
ID #:	Secondary Payer Source <input type="checkbox"/> yes <input type="checkbox"/> no
Street Address:	Start of Care:
City:	Diagnosis Code(s):
State: Zip:	

Requested Services: Initial Ongoing

- RN total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- HHA total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- PT total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- OT total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- ST total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- RT total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- SW total #visits: _____ frequency: _____ per _____ dates: _____ through _____
- PDN #hours: _____ frequency: _____ per _____ dates: _____ through _____

All the following information is RECOMMENDED to determine medical necessity:

- * Initial evaluation (for initial services only)
- * Current CMS-485 form
- * Home care records

Fax form to: 651-662-1004
Mail form to: Integrated Health Management, Route 472, PO Box 64668
St. Paul, MN 55164-0668