Excellus

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Home Health Care Recertification Form

Please complete and fax entire form. Incomplete information may delay review.

Member Name:_____ DOB: _____ Authorization #_____
Start of Care: ____/____/____ Diagnosis:_____
Agency Name: _____ Services Current in Home: _____
Contact Name:_____ Contact Phone #: ( )_____

Homebound Status (please explain):												
Primary Caregiver:												
Prior Level of Function (PLOF):												
Services Requested Circle/Add# Discharged date if closed	SN	PT	OT	ST	HHA	Other	SN	PT	OT	ST	HHS	Other
Function/Current	Eval Date: / /						Eval Date: / /					
Bed Mobility	Ind Sup CG Min Mod Max Total/Dep Assist 1 2						Ind Sup CG Min Mod Max Total/Dep Assist 1 2					
Transfer	Ind Sup CG Min Mod Max Total/Dep Assist 1 2						Ind Sup CG Min Mod Max Total/Dep Assist 1 2					
Ambulation	Ind Sup CG Min Mod Max Total/Dep Assist 1 2 Device: SW RW SC QCOther Distance:						Ind Sup CG Min Mod Max Total/Dep Assist 1 2 Device: SW RW SC QCOther Distance:					
ADL upper body Bathing/Dressing	Ind Sup CG Min Mod Max Total/Dep						Ind Sup CG Min Mod Max Total/Dep					
ADL lower body Bathing/Dressing	Ind Sup CG Min Mod Max Total/Dep						Ind Sup CG Min Mod Max Total/Dep Total/Dep					
Toileting	Ind Sup CG Min Mod Max Total/Dep Assist 1 2						Ind Sup CG Min Mod Max Total/Dep Assist 1 2					
Skilled Nursing												
Medications: IV/IM/SC												
Wound Care: Measurements/Tx												
Total Number of Visits from **ALL** Disciplines to Date												
Signature:												

Attestation: Health Plan reserves the right to request supporting medical documentation for approval determinations.