



**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