Custom Design Benefits

Date of Request:_____

HOME HEALTH SERVICE FORM

Patient Name: _____ **Member ID #** _____

Patient DOB: ___/___/_____ Patient Phone: (___) ____-_____ Different Last Name: _____

Ordering Physician: _____ Address: _____

City: _____ State: ____ Zip _____ Phone: (___) ____-_____ Fax: (___) ____-_____

Contact Person: _____ Fax: ( )____-_____ Contact Phone: (___) ____-_____ Ext: _____

Physician Tax ID#: _____ NPI#: _____

HOME HEALTH AGENCY (HHA):

Name: _____ Phone: (___) ____-_____

Address, City, State: _____

HHA Tax ID: _____ HHA NPI#: _____

HHA Contact Person: _____ Phone: (___) ____-_____ Fax: (___) ____-_____

CAREGIVER INFORMATION: Name: _____ Relationship: _____

Type of Assistance: _____ Phone: (___) ____-_____

CLINICAL INFORMATION AND SERVICES REQUESTED

Initial Service Date: ___/___/_____ DIAG ICD 10: _____

Recent Hospitalization- Admission Date: ___/___/_____Discharge Date: ___/___/_____

Reason for Hospitalization: _____

CPT CODE	SERVICE	START DATE	END DATE	# OF VISITS REQUESTED	ADDL VISITS REQUESTED
		___/___/_____	___/___/_____		
		___/___/_____	___/___/_____		
		___/___/_____	___/___/_____		
		___/___/_____	___/___/_____		

PLEASE PROVIDE ALL CLINICAL DOCUMENTATION FOR PROCESSING.

FAX TO: MMFAX@CUSTOMDESIGNBENEFITS.COM OR FAX TO 513-389-2997

This authorization is not a guarantee of payment. Plan benefits are based on the patient's eligibility at the time of service. For questions on eligibility and benefits call 513-598-2929/800-598-2929