

**DEEOIC Home Health
Authorization Request**

**Please ensure the prescription signed by the physician and the Case/Subscriber
Number is included with this authorization request.
Please submit fax to 1-800-882-6147.**

New Request

Amended Request

Date Requested _____ Requested by _____

Case/Subscriber Number _____

Claimant Name _____

Claimant Date of Birth (optional) _____

Provider Name _____

Conduent Provider Number _____

Provider Tax ID _____

Date(s) of Service Requested _____

ICD-9 Diagnosis Code(s)(for dates of service 09/30/15 and prior) _____

ICD-10 Diagnosis Code(s)(for dates of service 10/01/15 and after) _____

Procedure Code(s) and/or Modifier(s) (CPT/HCPCS/RCC):

- T1001 frequency _____ duration _____ total units _____
- T1017 frequency _____ duration _____ total units _____
- T1019 frequency _____ duration _____ total units _____
- T1020 frequency _____ duration _____ total units _____
- T1030 frequency _____ duration _____ total units _____
- T1031 frequency _____ duration _____ total units _____
- S5126 frequency _____ duration _____ total units _____
- S9122 frequency _____ duration _____ total units _____
- S9123 frequency _____ duration _____ total units _____
- S9124 frequency _____ duration _____ total units _____
- S9126 frequency _____ duration _____ total units _____

**All supporting documentation must be faxed to 1-800-882-6147.
Please ensure the Case/Subscriber Number is included on every faxed page.**