

General Authorization Information

*Patients Name:	DOB:
*Please select the nature of your request:	
□ Initial SOC notification (days 1-14)	
\Box SOC authorization request to continue services (days 15-60)	
Recert request for continuation of services. If yes, which cert period, 2_3_4_ or more	
\square Add additional visits or disciplines to an approved and open authorized certification period	
□ Resumption of care. Date of hospitalization:	
*Initial Start of Care (SOC) date:	
*Cert period dates being requested:	
*Please select each discipline and note the number of visits being requested (orders supporting these visits are required for review)	
SN/ # of visits SN need is for:	
PT/ # of visits	
OT/ # of visits	
□ST/ # of visits	
HHA/# of visits	
\Box MSW/ # of visits (Greater than 2 MSW visits will	require medical director review)
*If number of visits requested exceed the number of ordered visits, may we change the amount of visits to match the plan of care? Yes No	
*Date of last Face to Face encounter with ordering/certifying physician:	

*Please submit the most up-to-date Plan of care, OASIS, 485, current evaluation(s), and/or visit notes to support the requested service(s)

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage. The information in this form, including attachments, is privileged and confidential & is only for the use of the individual entities named in this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this

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