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Inspire (SNBC) Homecare Authorization Inquiry

Use this form only for skilled nursing and home health aide services

Member & Care Coordinator Information			
Date Inquiry sent to HealthPartners:	**(THIS IS DAY 1 OF 14 – please fax in ASAP)**		
Member Name:			
Member ID:		**DOB:**	
Entity Providing Care Coordination:			
Care Coordinator (CC) Name:		**CC Phone:**	
CC Email:			
Primary Care Physician:			
Clinic Name:		**Clinic Phone:**	

Service Information			
Service Discipline:	☐ SNV ☐ HHA		
Service Request Type:	☐ Ongoing Service Request	Auth Expiration Date:	
	☐ New Service Request		
Service Provider Name and Location:		**Tax ID:** (required)	
Frequency (i.e. 3 visits per week)		**Phone #:**	
Total visits in auth period:		**Fax #:**	
HPCP Code (required)**:**		**Cost:**	
Requested Start Date:			
Primary diagnosis (include description, not just codes):			
Alternative resources CC has researched/attempted: Quasi formal services: Informal services: Other:			

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Rationale to support requested service(summarize the medical/mental health needs):

List current services member receives (or attach current service agreement):

Medical Necessity Criteria – must complete this section:

For SNV services only, Care Coordinator has confirmed that member:

☐ Meets Medical Assistance home care criteria for medication/health management by all of the following indicators:

- Needs cannot be met by Pharmacy, outpatient or ambulatory services
- Has no family or other personnel available/able to complete cares
- Member is physically and/or mentally unable to perform cares or self-administer meds

☐ Does not meet Medical Assistance home care criteria above – Benefit Exception is requested

- This form will serve as the BEI request
- Rationale provided on this form supports the need for benefit exception

For HHA services only:

☐ Rationale provided on this form supports the need for this service

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****** For internal use only:***

Outcome				
☐ Service Approved	**Start Date:**		**End Date:**	
☐ Service Not Approved				

Delegate: Please select one of the following and return to HealthPartners within 3 business days.

☐ Member in Agreement: No DTR to be issued
☐ Member in Disagreement: DTR to be issued

HealthPartners SNBC Supervisor **Date**

Once completed, submit this form via secure email to:

HPSNBC_CC@healthpartners.com
-OR-
Send via RightFax to: (952) 853-8723