ITASCA MEDICAL CARE (IMCare)
Home Care Providers - Request for Services
Fax: (218) 327-5545 Telephone: (218) 327-6188

Submission of this form does not guarantee approval. Forms submitted with incomplete data cannot be reviewed and will be returned to your office. Benefits are subject to eligibility and the time service is rendered

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DATE: _____ HOME CARE PROVIDER: _____/County_____

PROVIDER'S CONTACT NAME: _____ PHONE: _____

Name /number of person completing this form: _____

PATIENT'S NAME: _____DOB: _____
Last First MI

SEX: ☐-male ☐-female IMCARE ID #: _____

DX: _____PRACTITIONER:_____

*****HOMECARE ONLY:**

☐ I attest that the member had a face-to-face encounter with a physician, NP or PA, related to the primary reason home health services are required. The visit occurred within 90 days before or 30 days after the home health services were initiated. I will retain a copy of this face-to-face encounter as part of this member's health record and will submit to IMCare upon request.

Medicare Qualified Service: *☐-yes ☐-no*

***Circle Correct Code*:**

_____Skilled Nursing Visits – T1030 RN
***Authorization required after 9 visits, per calendar year
Combined with T1031
_____Skilled Nursing Visits – T1031 LPN
***Authorization required after 9 visits, per calendar year
Combined with T1030
_____RN Supervision of PCA – T1019 (UA) # of Units _____

****ATTACH****
- Dr. Order/Statement of Need
- PCA Assessment Form
- HCFA 485 – Home Health Cert Form

_____Personal Care Attendant (PCA) Assessment: ☐-Initial – T1001 ☐-Reassess – T1001 (TS)
☐-Service Update – T1001 (TS) ☐-Temporary Service Increase – T1001 (U6)

_____Personal Care Attendant Visits – T1019 (15 min), 1:1 # of Units _____

_____Personal Care Attendant Visits – T1019 (TT/HQ) (15 min), shared # of Units _____

_____Home Health Aide Visits – T1021

_____Other: _____

Home Care Rating_____
Critical ADL's _____
Complex Medical Needs_____
Level I Behaviors _____
Total Units w/Supervision & PCA combined_____

FREQUENCY/DURATION: _____

START DATE OF SERVICE: _____ ***END DATE OF SERVICE:*** _____

IMCare Office Use Only

☐ ***Approved*** ☐ ***Not Approved*** _____ _____
Medical Director Signature ***Date***

Comments/Request: _____