Home Health and Hospice

Fax completed form to: 608-252-0830

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUEST INFORMATION		
☐ Home Health ☐ Hospice		
Date (s) of Service:	Diagnosis Code(s):	ICD Code(s):
CPT Codes and Description:		
# of Visits	3rd party liability: ☐ W/C ☐ MVA ☐ Other	

Services Requested:

Form Submitted By:		
Name:	Phone:	Fax:

For further information on hospice services, please see the Dean Health Plan medical policy; Hospice MP9299.

Underwritten by Dean Health Plan, Inc.
If you have any questions regarding the services or form, please contact Customer Service at 877-230-7555 or review Prevea360 Health Plan's Medical Management site.
Requests to non-plan providers must be approved prior to obtaining services.
Updated: 04/2014