SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711

Home Health

Prior Authorization Request

Date _____

To be completed by home health provider		Date (month/day/year) / /
Patient name (print)	SMID	Date of birth (month/day/year) / /
Home health agency name	Home health agency phone	Home health agency fax
Physician name	Physician phone	
Diagnosis (ICD code)		

Requested Services	Frequency	Duration	Medications
☐ Registered nurse			
☐ Home health aide			
☐ Physical therapist			
☐ Occupational therapist			
☐ Speech therapist			
☐ Social worker			
☐ Hospice			

Physician orders (include any specific orders for activity, therapy and treatment) _____

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to: Security Health Plan
Health Services Department
PO Box 8000
Marshfield, WI 54449-8000
Fax 715.221.6616

Marshfield Clinic providers route to:
Health Services Department
Routing location, SHP

If you have any questions, please contact Provider Assistance at 1.800.472.2363.

