Jefferson Health Plans | Health Partners Plans

Shift Care Authorization Request

Shift Care Fax Information	
To: Jefferson Health Plans dba Health Partners plans **Shift Care Fax # (267) 515-6667**	**Requesting/ordering Provider Name:**
	NPI #:
Contact Name:	**Phone #:**
Date:	**Fax #:**

Provider – Please Complete Area Below		
Member Name:	**Member ID #:**	**Member's DOB:**
Level of care requested (Skilled Nursing or Home Health Aide): **What days are the service being requested for?** **How many hours of service are requested?** **Why the number of hours requested is necessary?** **What are the skilled health care needs? (G-tube feeds, vent care, TPN, etc)** **What activities of daily living are hands on/ help needed for? (Bathing, dressing, toileting, ambulation, eating, or grooming)** **Shift care/ Medical Day Care (MDC):**		
Duration of Service (up to 6 months):		
Agency Name:	**Agency Contact #**	
Agency NPI #:	**Agency Fax #**	
ICD 10/Diagnosis:	☐ **New** ☐ **Ongoing** ☐ **Change (Increase/Decrease/Level of Care)**	

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.

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Attached with Request (Check all that apply)	
☐ Letter of Medical Necessity (LOMN)	☐ Recent Office Visit Notes (within the last 6 months)
☐ Head of Household (HOH) Work Verification Letter (letter should list days and hours worked).	☐ HOH Letter from their treating MD if disabled and not working. (letter must indicate HOH limitations and duration of limitations)
☐ School Schedule (if school aged)	☐ School Letter giving permission for services in school, if applicable
☐Autism Diagnostic Report	☐ Individualized Educational Plan (IEP)
☐ Recent signed Plan of Care (within 6 months)	☐ Nursing Notes
☐Home Health Aide Logs	