PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

PALMETTO GBA
A CELERIAN GROUP COMPANY

JM HH PRE-CLAIM REVIEW SUBMISSION REQUEST

All fields are REQUIRED unless otherwise noted. Incomplete or handwritten requests will be returned.

Check the appropriate box below:

☐ Initial Submission

☐ Resubmission Enter UTN of most recent submission: _____

If this is a resubmission, each subsequent billing period must be submitted on a seperate form.

If this is a resubmission, do you have a copy of the most recent Non-Affirmation decision letter for this billing period?

Choose an item:

Note: Use of this request document will require submission via fax, hard copy mail, or the electronic submission of Medical Documentation (esMD). To save time, use our eServices web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Provider Information

Contract/Region
11001

Provider Number (PTAN)

Provider/Facility Name

National Provider Identifier (NPI)

Provider/Facility Address Line 1

Requestor Name

Provider/Facility Address Line 2 (if applicable)

Requestor Phone Number

Ext. (if applicable)

Provider/Facility City

Fax (if applicable)

Provider/Facility State

Provider/Facility ZIP

Requestor E-mail

A decision letter will be mailed to the address provided above. If desired, the provider may enter a fax number to which the decision letter will be sent.

Ordering/Referring Physician Name

Ordering/Referring Physician NPI

Ordering/Referring Physician Address Line 1

Ordering/Referring Phys. Address Line 2 (if applicable)

Ordering/Referring Physician City

Ordering/Referring Phys. State

Ordering/Referring Phys. ZIP

Attending Physician Name

Attending Physician NPI

Attending Physician Address Line 1

Attending Physician Address Line 2 (if applicable)

Attending Physician City

Attending Physician State

Attending Physician ZIP

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Beneficiary/Patient Information

Beneficiary/Patient First Name

Beneficiary/Patient Date of Birth (mm/dd/yy)

Beneficiary/Patient Last Name

Beneficiary Gender
Choose an item:

Beneficiary/Patient Medicare Number

Claim Information

Type of Bill (TOB):
Choose an item:

HCPCS

Check all that apply:

☐ G0151 ☐ G0152 ☐ G0153 ☐ G0155 ☐ G0156 ☐ G0157 ☐ G0158 ☐ G0159
☐ G0160 ☐ G0161 ☐ G0162 ☐ G0299 ☐ G0300 ☐ G0493 ☐ G0494 ☐ G0495
☐ G0496 ☐ G2168 ☐ G2169

Pre-Claim Review Billing Period Start Date (mm/dd/yy)

Pre-Claim Review Billing Period End Date (mm/dd/yy)

Requestor Printed Name

Requestor Signature

Date (mm/dd/yy)

Documentation Requirements

Responses to the following questions will generate cover pages for the various types of documentation required for review. Please ensure that you attach the appropriate documentation associated with each cover page printed before submitting your request.

Q1 Was the beneficiary admitted to your home health agency directly from an acute or post-acute facility?

Choose an item:

Choose facility type:

Q2 Was the home health certification and face-to-face (F2F) encounter performed by the same physician?

Choose an item:

What provider type performed the F2F encounter?

Task #1: Attach the actual F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services or upload supporting documentation as to why the F2F is not applicable

Q3 Do you have any home health agency (HHA) generated records (for example patient's comprehensive assessment) that have been signed, dated, and incorporated into the certifying physician's medical records?

Choose an item:

Task #2: Attach the HHA generated records that have been signed, dated, and incorporated into the certifying physician's medical records.

Task #3: Attach the plan of care established and periodically reviewed by an authorized physician

Task #4: Attach the signed and dated physician's certification of patient eligibility

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Additional Eligibility Requirements

Under each of the Medicare Home Health requirements below, please attach the medical records that meet each requirement

Criteria 1: Confined to the Home:

Q4 Does the beneficiary, because of illness or injury, need (check all that apply):

- [ ] The aid of supportive devices such as crutches, canes, wheelchairs, and walkers?
- [ ] The use of special transportation?
- [ ] The assistance of another person to leave their place of residence?

If one or more of the above apply, proceed to Task 5

If none of the above applies, proceed to Q5

Q5 Does the beneficiary have a condition such that leaving the home is medically contraindicated?

Choose an item:

Task #5 - Q4/Q5: Attach medical documentation that meets the First Criteria for Confined to the Home

Criteria 2: Confined to the Home

Q6 Component 1: Is there a normal inability to leave the home?

Choose an item:

Task #5 - Q6: Attach medical documentation that meets the Second Criteria for Confined to the Home

Q7 Component 2: Does leaving the home require a considerable and taxing effort?

Choose an item:

Checklist 1: Is there a structural impairment? If yes, select all that apply below:

- [ ] a. Structures of the nervous system
- [ ] b. Eye, ear and related structures
- [ ] c. Structures involved in voice and speech
- [ ] d. Structures of the cardiovascular system
- [ ] e. Structures of the immunological system
- [ ] f. Structures of the respiratory system
- [ ] g. Structures of the digestive system
- [ ] h. Structures related to the metabolic and endocrine systems
- [ ] i. Structures of the genitourinary system
- [ ] j. Structures related to movement
- [ ] k. Skin and related structures

Checklist 2: Is there functional impairment? If yes, select all that apply below:

- [ ] a. Mental functions
- [ ] b. Sensory functions and pain
- [ ] c. Voice and speech functions
- [ ] d. Functions of the cardiovascular system
- [ ] e. Functions of the hematological and immunological systems

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- [ ] f. Functions of the respiratory system
- [ ] g. Functions of the digestive system
- [ ] h. Functions of the metabolic and endocrine systems
- [ ] i. Genitourinary functions
- [ ] j. Neuromusculoskeletal and movement-related functions
- [ ] k. Functions of the skin and related structures

Checklist 3: Is there an activity limitation? If yes, select all that apply below:

- [ ] a. Communication
- [ ] b. Mobility
- [ ] c. Self-care
- [ ] d. Domestic life
- [ ] e. Interpersonal interactions and relationships

Task#5 - Q7: Attach medical documentation that meets the Second Criteria for Confined to the Home

Instructions for completing this request:

1. **All** fields are required. Requests submitted without all fields completed will be returned as an incomplete request.
2. Complete all fields online. Handwritten requests will not be processed and will be returned as an incomplete request.
3. This request may not be saved after it is completed.

Documentation Requirements:

Note: Documentation header pages will print with this request. Ensure that all relevant documentation is attached behind the appropriate header page.

1. If this is a resubmission, ensure that you entered the UTN and a copy of the most recent Non-Affirmation decision letter for this billing period is attached.
2. Task # 1: F2F Clinical Encounter Notes.
3. Task #2: HHA generated records that have been signed, dated, and incorporated into the certifying physician's medical records (if applicable).
4. Task #3: Plan of care signed and dated by the certifying physician.
5. Task #4: Signed and dated physician's certification.
6. Task #5 – Q4/Q5: Medical documentation that meets the criteria 1, which supports that the patient is confined to the home.
7. Task #5 – Q6: Documentation to meet criteria 2, which supports the patient's normal inability to leave the home.
8. Task #5 – Q7: Documentation that meets criteria 2, which supports that it is a considerable and taxing effort for the patient to leave the home.

Subsequent Billing Period 2 **Use for initial submissions only.**

Type of Bill (TOB): Choose an item:

HCPCS Check all that apply:

- [ ] G0151 [ ] G0152 [ ] G0153 [ ] G0155 [ ] G0156 [ ] G0157 [ ] G0158 [ ] G0159
- [ ] G0160 [ ] G0161 [ ] G0162 [ ] G0299 [ ] G0300 [ ] G0493 [ ] G0494 [ ] G0495
- [ ] G0496 [ ] G2168 [ ] G2169

Pre-Claim Review Billing Period Start Date (mm/dd/yy)

Pre-Claim Review Billing Period End Date (mm/dd/yy)

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Subsequent Billing Period 3

Use for initial submissions only.

Type of Bill (TOB): Choose an item:

HCPCS — Check all that apply:

☐ G0151 ☐ G0152 ☐ G0153 ☐ G0155 ☐ G0156 ☐ G0157 ☐ G0158 ☐ G0159
☐ G0160 ☐ G0161 ☐ G0162 ☐ G0299 ☐ G0300 ☐ G0493 ☐ G0494 ☐ G0495
☐ G0496 ☐ G2168 ☐ G2169

Pre-Claim Review Billing Period Start Date (mm/dd/yy)

Pre-Claim Review Billing Period End Date (mm/dd/yy)

Subsequent Billing Period 4

Use for initial submissions only.

Type of Bill (TOB): Choose an item:

HCPCS — Check all that apply:

☐ G0151 ☐ G0152 ☐ G0153 ☐ G0155 ☐ G0156 ☐ G0157 ☐ G0158 ☐ G0159
☐ G0160 ☐ G0161 ☐ G0162 ☐ G0299 ☐ G0300 ☐ G0493 ☐ G0494 ☐ G0495
☐ G0496 ☐ G2168 ☐ G2169

Pre-Claim Review Billing Period Start Date (mm/dd/yy)

Pre-Claim Review Billing Period End Date (mm/dd/yy)

Subsequent Billing Period 5

Use for initial submissions only.

Type of Bill (TOB): Choose an item:

HCPCS — Check all that apply:

☐ G0151 ☐ G0152 ☐ G0153 ☐ G0155 ☐ G0156 ☐ G0157 ☐ G0158 ☐ G0159
☐ G0160 ☐ G0161 ☐ G0162 ☐ G0299 ☐ G0300 ☐ G0493 ☐ G0494 ☐ G0495
☐ G0496 ☐ G2168 ☐ G2169

Pre-Claim Review Billing Period Start Date (mm/dd/yy)

Pre-Claim Review Billing Period End Date (mm/dd/yy)

To fax or mail this request, send it to:

Fax: 803-419-3263
Palmetto GBA – Review Choice Demonstration
P.O. Box 100131, Columbia, SC 29202-3131

PRINT REQUEST

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Most Recent Non-Affirmation Decision Letter for This Billing Period *(resubmissions only)*

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Task #1
F2F Clinical Encounter Notes

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Task #2
HHA Generated Records

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Task #3
Plan of Care

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Task #4
Signed and Dated
Physician's Certification

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Task #5 - Q4/Q5
Documentation that Meets Criteria 1 – Confined to the Home

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Task #5 - Q6

Documentation that meets Criteria 2 – Patient's Inability to Leave the Home

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Task #5 - Q7

Documentation that Meets Criteria 2 – Considerable and Taxing Effort to Leave the Home

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Subsequent Billing Period 1
Plan of Care

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Subsequent Billing Period 2
Plan of Care