

# Home Health Plan of Care (POC) Instructions

Use the guidelines below in filling out the Home Health Plan of Care (POC) form. Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.

<b>Section A: Client Information</b>	
Client's name*	Last name, first name, middle initial
Date of birth*	Date of birth given by month, day and year
Date last seen by physician or allowed practitioner	Client must be seen by a physician or allowed practitioner within 30 days of the initial start of care and at least once every 6 months thereafter unless a diagnosis has been established by the physician or allowed practitioner and the client is currently undergoing physician or allowed practitioner care and treatment
Medicaid number*	Nine-digit number from client's current Medicaid identification card
<b>Section B: Rendering Home Health Agency (HHA) Information</b>	
Name*	Name of Home Health agency
License number	Medical license number issued by the state of Texas
Street address*	Agency street address
ZIP + 4*	Agency ZIP + 4 Code
Telephone	Area code and telephone number of agency
Tax ID*	Tax Identification Number (TIN)
NPI*	National Provider Identifier number (10-digit) of agency
Taxonomy*	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
Benefit Code*	Code identifying state program for the service provided
<b>Section C: Prescribed Pediatric Extended Care Center (PPECC) Provider Information (If known, Home Health Agency to complete this section if client receives PPECC services)</b>	
Name	Name of PPECC provider
Fax	Number that the PPECC provider can be reached by fax
Telephone	Area code and telephone number of PPECC provider
Address	Provider mailing address (street, city, state, and ZIP + 4 Code)
Tax ID	Tax Identification Number (TIN)
NPI	National Provider Identifier number (10-digit)
Taxonomy	Ten-character Taxonomy code showing service type, classification, and specialization of the medical service provided by the agency
Benefit code	Code identifying state program for the service provided
PPECC hours of operation	Provide the PPECC's hours of operation for client services, including time zone. For example, 7 a.m. – 7 p.m., Central Time
<b>Section D: Requesting Physician or Allowed Practitioner Information</b>	
Name*	Name of physician or allowed practitioner
License number	Physician or allowed practitioner's medical license number issued by the state of Texas
Telephone	Area code and telephone number of physician or allowed practitioner
Tax ID	Tax Identification Number (TIN) of requesting physician or allowed practitioner
NPI*	National Provider Identifier number (10-digit) of requesting physician or allowed practitioner

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<b>Section E: Plan of Care Information</b>	
Status	Indicate with a check mark if POC is for a new client, extension (services need to be extended for an additional 60 day period) or a revised request
Original SOC date	First date of service in this 365 day benefit period
Revised request effective date	Date revised services, supplies or DME became effective
Services client receives from other agencies	List other community or state agency services client receives in the home. Examples: primary home care (PHC), community based alternative (CBA), etc.
Diagnoses	Diagnosis codes related to ordered home health services. For reimbursement, diagnoses must match those listed on the claim and be appropriate for the services ordered.
Functional limitations/ Permitted activities	Include on revised request only if pertinent
Prescribed medications	List medications, dosages, routes, and frequency of dosages (include on revised request if applicable)
Diet ordered	Examples: Regular, 1200 cal. ADA, pureed, NG tube feedings, etc. (include on revised request if applicable)
Mental status	Examples: alert and oriented, confused, slow to learn, etc. (include on revised request if applicable)
Prognosis	Examples: good, fair, poor, etc. (include on revised request if applicable)
Rehabilitation potential	Potential for progress, examples: good, fair, poor, etc. (include on revised request if applicable)
Safety precautions	Examples: oxygen safety, seizure precautions, etc. (include on revised request if applicable)
Medical necessity, clinical condition, treatment plan	Describe medical reason for all services ordered, nursing observations pertinent to the plan of care, and the proposed plan of treatment.
HCPCS service requested*	Enter the HCPCS services requested
Requested dates of service from*	Enter the beginning date of service
Requested dates of service to*	Enter the ending date of service
SNV, HHA*	State the number of visits requested for each type of service authorized (not applicable for private duty nursing requests)
Supplies	List all supplies authorized
DME	List each piece of DME authorized, check whether DME is owned, if DME is to be repaired, purchased, or rented, and for what length of time the equipment will be needed
RN signature	The signature and date this form was filled out and completed by the RN
From and to dates	Dates (up to 60 days) of authorization period for ordered home health services
Conflict of interest statement	Relevant to the physician signing this form; physician should check box if exception applies
Physician or allowed practitioner signature and date signed	The physician or allowed practitioner's signature and the date the form was signed by the physician or allowed practitioner ordering home health services