# 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. | |
|---|---|
| **Section A: Client Information** | |
| 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 doctor | Client must be seen by a physician 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 and the client is currently undergoing physician care and treatment |
| Medicaid number* | Nine-digit number from client's current Medicaid identification card |
| **Section B: Rendering Home Health Agency (HHA) Information** | |
| 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 |
| **Section C: Prescribed Pediatric Extended Care Center (PPECC) Provider Information (If known, Home Health Agency to complete this section if client receives PPECC services)** | |
| 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 |
| **Section D: Requesting Physician Information** | |
| Name* | Name of Physician |
| License number | Physician's medical license number issued by the state of Texas |
| Telephone | Area code and telephone number of physician |
| Tax ID | Tax Identification Number (TIN) of requesting physician |
| NPI* | National Provider Identifier number (10-digit) of requesting physician |

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| Section E: Plan of Care Information | |
|---|---|
| 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/<br>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 signature and date signed | The physician's signature and the date the form was signed by the physician ordering home health services |