ITASCA MEDICAL CARE (IMCare)
Home Care Providers - Request for Services
Fax: (218) 327-5545 Telephone: (218) 327-6188

Submission of this form does not guarantee approval. Forms submitted with incomplete data cannot be reviewed and will be returned to your office. Benefits are subject to eligibility and the time service is rendered

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DATE: __________ HOME CARE PROVIDER: ____________________________________/County_______

PROVIDER'S CONTACT NAME: __________________________________ PHONE: ________________________

Name /number of person completing this form: ____

PATIENT'S NAME: ____DOB: ______________
Last First MI

SEX: ☐-male ☐-female IMCARE ID #: _________________________

DX: ____PRACTITIONER:_________________________________

*****HOMECARE ONLY:**

☐ I attest that the member had a face-to-face encounter with a physician, NP or PA, related to the primary reason home health services are required. The visit occurred within 90 days before or 30 days after the home health services were initiated. I will retain a copy of this face-to-face encounter as part of this member's health record and will submit to IMCare upon request.

Medicare Qualified Service: ☐-yes ☐-no

Circle Correct Code:

****ATTACH****

- Dr. Order/Statement of Need
- PCA Assessment Form
- HCFA 485 – Home Health Cert Form

________Skilled Nursing Visits – T1030 RN
***Authorization required after 9 visits, per calendar year
Combined with T1031

________Skilled Nursing Visits – T1031 LPN
***Authorization required after 9 visits, per calendar year
Combined with T1030

________RN Supervision of PCA – T1019 (UA) # of Units ______

________Personal Care Attendant (PCA) Assessment: ☐-Initial – T1001 ☐-Reassess – T1001 (TS)
☐-Service Update – T1001 (TS) ☐-Temporary Service Increase – T1001 (U6)

________Personal Care Attendant Visits – T1019 (15 min), 1:1 # of Units _________
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________Personal Care Attendant Visits – T1019 (TT/HQ) (15 min), shared # of Units _____

________Home Health Aide Visits – T1021

________Other: ____

Home Care Rating________
Critical ADL's ________
Complex Medical Needs______
Level I Behaviors _________
Total Units w/Supervision & PCA combined____________

FREQUENCY/DURATION: ____

START DATE OF SERVICE: _________________ *END DATE OF SERVICE: ________________*

IMCare Office Use Only
☐ *Approved* ☐ *Not Approved* _________________________________ ________________ *Medical Director Signature* *Date* *Comments/Request:* ____

S:\|MARKETING\|Web Site Information\|Providers\|Provider Forms & Documents\|home care request UPDATED 010820.doc 11/03; updated 6/04, 10/04, 8/06, 10/06, 10/08, 8/09, 2/12, 8/17, 1/20