

SC Department of Health and Human Services
Division of Community and Facility Services, Dept. of Community Services: 803-898-2590
Request to Exceed 50 Visit Limitation for Home Health Services

Date of Request: _____

Section I: PROVIDER INFORMATION

Home Health Agency Name: _____ Medicaid Legacy Provider Number: _____

Contact Person's name, phone number and email: _____

Section II - A: RECIPIENT / PATIENT INFORMATION:

Recipient Name: _____ Recipient Medicaid ID: _____

Diagnosis (include ICD-9 code): _____

Extenuating Circumstances: _____

Section II - B: REQUEST FOR SERVICES:

Name of Physician Ordering Service(s): _____

Phone number and email address: _____

Specify Additional Services Requested: _____

Number of Visits Requested Per Service: _____ Duration requested: _____

Estimated Cost: _____

Please attach executive summary describing in detail the extenuating circumstances which make additional visits medically necessary. Please also include any supporting medical documentation which would document the necessity for the additional home health visits.

Physician Signature and Date: _____

Section III: SCDHHS RESOLUTION (To be completed and signed by SCDHHS staff)

_____ Approved _____ Denied

Number of Visits Approved: _____ Approved Duration: _____

Reason for Denial: _____

SCDHHS Signature and Date: _____

Send Form to:

SC Department of Health and Human Services ATTN: Home Health, 7th Floor PO Box 8206 Columbia, SC 29202-8206