

*Place Health Plan  
Logo Here*

**UNABLE TO PROCESS YOUR REQUEST FOR AUTHORIZATION**

**DATE:**  
**TO:**  
**AGENCY NAME:**  
**FROM:**  
**PATIENT NAME:**

**FAX:**  
**FAX:**

**YOUR REQUEST FOR AUTHORIZATION OF SERVICES IS BEING DELAYED BECAUSE THE FOLLOWING INFORMATION HAS NOT BEEN PROVIDED:**

<input type="checkbox"/> START OF CARE DATE	<input type="checkbox"/> DME / SUPPLIES / IV / LAB
<input type="checkbox"/> AGENCY DISCHARGE DATE	<input type="checkbox"/> CAREGIVER
<input type="checkbox"/> MD AGREES WITH DISCHARGE	<input type="checkbox"/> FUNCTIONAL STATUS
<input type="checkbox"/> PATIENT AGREES WITH DISCHARGE	<input type="checkbox"/> FROM TO DATE MISSING
<input type="checkbox"/> PATIENT INFORMATION	<input type="checkbox"/> NUMBER OF REQUESTED VISITS
<input type="checkbox"/> HOMEBOUND STATUS	<input type="checkbox"/> SOC DATE DOES NOT MATCH INITIAL DISCIPLINE DATE
<input type="checkbox"/> DIAGNOSIS	<input type="checkbox"/> DISEASE SPECIFIC INFORMATION NOT PROVIDED
<input type="checkbox"/> MD INFORMATION	<input type="checkbox"/> INTERVENTION / EDUCATION PLAN NOT CLEAR
<input type="checkbox"/> INSURANCE #	<input type="checkbox"/> GOALS NOT PATIENT SPECIFIC
<input type="checkbox"/> INFORMATION NOT LEGIBLE	<input type="checkbox"/> OTHER
<input type="checkbox"/> AGENCY INFORMATION	

**PLEASE RETURN THE ABOVE INFORMATION AS SOON AS POSSIBLE SO THAT THE AUTHORIZATION PROCESS CAN BE COMPLETED.**

**THANK YOU!**

**\*\*\*\*Confidentiality Notice\*\*\*\***

***Place Health Plan Confidentiality Notice Here***