Professional Heath Care Network

To complete this form on-line please visit: https//PROHCN.COM or upload documents to the ROC portal

HOME HEALTH CARE REQUEST RESUMPTION OF CARE FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 877-612-7066

Questions? Call (602)-395-5100

Date of Request:	**Date of TIF:**	**Agency Name:** **NPI:**
		Contact Name:
Date of ROC:	**Date of facility DC:**	**Phone:**
		Fax: **Email:**
		Send Approved Auth to: ☐ **Email** or ☐ **Fax**
Patient Name:		**Clinician Name:**
DOB:		**Phone:** **Fax:**
Patient State of Residence:		**Email:**

Select discipline still active below:

SN: ☐ PT: ☐ OT: ☐ ST: ☐ MSW: ☐ HHA: ☐

Please indicate the amount of visits remaining for each discipline below:

SN: ☐ PT: ☐ OT: ☐ ST: ☐ MSW: ☐ HHA: ☐

Please provide Referral ID # :

***Please attach resumption of care orders and inpatient documentation

Comments