FOR FASTER AUTHORIZATION,
PLEASE VISIT:
https://providers.carelonmedicalbenefitsmanagement.com/postacute/

carelon

Inpatient Rehabilitation Facility Concurrent Request Form

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-623-3039
Questions? Call 800-222-9579

Date of Request:	☐ Standard ☐ Retro	☐ Urgent Request *Note: Expedited organization determinations (urgent requests), can only be requested by the Member (or their representative) or a Physician. See CMS Chapter 13 regulation: 50.1*

Member Information:		
Member Name:	Member ID:	Date of Birth:

Requesting IRF Facility Information		
Facility Name:		
NPI:	Attending Physician:	Is there a medical power of attorney? ☐ Yes ☐ No ☐ Unknown
Phone:	Attending Physician NPI:	
Fax:		Name and relationship to patient:
IRF Facility Contact Name:	IRF admission date:	
IRF Facility Contact Phone:	Anticipated IRF Discharge date:	*If available, please attach POA/AOR with request*
IRF Facility Contact Fax:	Is member currently in your facility? ☐ Y ☐ N	Does the patient have an advanced directive? ☐ Yes ☐ No ☐ Unknown

INSTRUCTIONS

Submission MUST include the following as part of your referral package:

- ☐ All pages of this referral form (fully completed – include comments).
- ☐ Rehabilitation H & P
- ☐ Specialty consultations
- ☐ Overall plan of care
- ☐ Admission Orders
- ☐ Current medication list/record
- ☐ Interdisciplinary Team Assessment
- ☐ 3 days of most recent physician notes.
- ☐ 1-2 days of most recent nursing notes.
- ☐ 1-2 days of most recent wound care notes, if applicable.
- ☐ Therapist assessment/ current progress notes that provide relevant supplemental information. (e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST.
- ☐ Most recent diagnostics (CT scans / X-ray reports) and lab work.

MEDICAL AND PHYSICAL STATUS

Admitting ICD-10 Code(s)			
1 (Primary)	2	3	4

Clinical Category			
☐ Stroke	☐ Neurologic Disorder- NOS	☐ Fracture of Femur	☐ Major Multiple Trauma
☐ Spinal Cord Dysfunction	☐ Arthritis- Inflammatory or severe degenerative	☐ Burns	☐ Medically Intensive
☐ Brain Injury	☐ Knee or Hip Replacement	☐ Amputation	☐ Other

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Reason For Continued Rehabilitation Stay:

Past Medical History/Other Medical Conditions:

Risk of Complications: Select One	
Expected Overall Level of Improvement: Select One	Rehabilitation Potential: Select One

Select all the following skilled services the patient will require for post-acute care.	
☐ Medical and/or nursing care	Anticipated frequency: ☐ Daily ☐ Every other day ☐ Weekly ☐ Unknown
☐ Physical therapy to address functional impairment	Anticipated Frequency:____hours/day____# days/week
☐ Occupational therapy to address functional impairment	Anticipated Frequency:____hours/day____# days/week
☐ Speech therapy to address functional impairment	Anticipated Frequency:____hours/day____# days/week

Most recent vitals: Temp _____ Pulse_____RR _____BP_____O2 sat _____

Weight_____Height _____

Alert and oriented _____ Able to follow commands? ☐ Yes ☐ No Episodes of agitation? ☐ Yes ☐ No

Increased confusion at night? ☐ Yes ☐ No

Medical Needs – If any boxes are checked please provide details.

- ☐ Open Wounds
- ☐ Infections (list)
- ☐ IV Therapy
- ☐ Oxygen/Respiratory Treatments
- ☐ Trach
- ☐ Vent
- ☐ Pain
- ☐ Dialysis
- ☐ 1:1 Supervision
- ☐ Ongoing outpatient medical treatments. (i.e.: radiation/chemotherapy)

Details: _____

Nutrition Needs: Select One

TPN Details:

Current Level of Function:

Date of Current Therapy Status:	
Weight Bearing Status: Select One	
Ambulation: Select One	# Feet:
Wheelchair Mobility (if applicable): Select One	
Bed Mobility: Select One	
Transfers: Select One	
Stairs: Select One	#Stairs
Feeding: Select One	
Grooming/Hygiene: Select One	
Bathing: Select One	
Dressing: Select One	
Toileting: Select One	
DME Needed Select One	

Discharge Planning (general):	
Previous living situation ☐ Home alone ☐ Home with spouse ☐ Home with family/caregiver ☐ Long Term Care ☐ Supportive Housing ☐ Homeless ☐ Unknown ☐ Other (describe):	Planned d/c living situation ☐ Home alone ☐ Home with spouse ☐ Home with family/caregiver ☐ Long Term Care ☐ Supportive Housing ☐ Homeless ☐ Unknown ☐ Other (describe):
For discharge plans to return home	**For discharge plans to long term care or supportive housing**
Is there a caregiver identified and able to assist the patient? Select One [IF YES] Select One [IF YES] Caregiver ability to provide care: Select One [IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? Select One [IF YES] Has caregiver training been completed? Select One Home Living Environment: # of steps to enter:_____ Rails: Select One Is there a ramp to enter? Select One Bed 1st Floor Select One Bath 1st Floor Select One Is there ability for first floor setup? Select One If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? Select One If yes, Name of Company:	Has a facility been chosen? Select One [IF YES] Name of facility: Has an application been completed? Select One Is it anticipated that a bed/room be available for the patient? Select One Is it anticipated that the facility will be able to provide the level of care needed at discharge? Select One Does patient require an application for Medicaid? Select One Discharge Plan Comment:

Comments or other pertinent information:

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