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

carelon

Initial Inpatient Rehabilitation Facility Authorization Request Form

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: *833-623-3037*
Questions? Call *877-291-0509*

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 Rehab Facility Information	*Referral Source Information*	
Facility Name: Tax ID:	Referral Source Type: ☐ Hospital ☐ SNF ☐ IRF ☐ LTACH ☐ Physician Office ☐ Emergency Dept ☐ Psychiatric Hosp/Unit	Ordering Physician:
		Ordering Physician NPI:
NPI:		Ordering Physician Tax ID
Phone:	Referral Source:	Date of Onset of Illness/Injury:
Fax:	Referral Source NPI:	Hospital admission date:
IRF Facility Contact Name:	Referral Source Contact Name:	Anticipated Rehab Admit Date:
IRF Facility Contact Phone:	Referral Source Contact Phone:	Is member currently in your facility? ☐ Y ☐ N
IRF Facility Contact Fax:		

INSTRUCTIONS

Submission
MUST include the following as part of your referral package:
- ☐ All pages of this referral form (fully completed – include comments)
- ☐ Hospital H&P (if applicable)
- ☐ 1-2 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
- ☐ Specialty consultations
- ☐ Therapist assessment/ current progress notes that provide relevant supplemental information (e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST
- ☐ Diagnostics (CT scans / X-ray reports) and most recent lab work
- ☐ Current medication list/record
- ☐ Preadmission assessment (optional)

Please attest to the following: (NOTE: All the following requirements must be met for request to meet medical necessity criteria)
- ☐ The patient is medically stable with medical or surgical comorbidities that do not require ongoing acute medical attention.
- ☐ There is a reasonable expectation that the requested level of skilled care is necessary to achieve therapeutic goals.
- ☐ Improvement is expected in a reasonable and predictable period of time.
- ☐ The patient's condition has reasonable potential to respond favorably to skilled therapies, medical, and/or nursing care.
- ☐ The patient is physically and mentally capable of participating in 3 hours of therapy, 5x/week, or at least 15 hours of intensive rehabilitation within a 7-day consecutive calendar day or period.

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

Is there a caregiver identified and able to assist the patient at home? ☐ Yes ☐ No ☐ Unknown Previous living situation ☐ Home alone ☐ Home with family/caregivers ☐ Residential care/LTC ☐ Homeless ☐ Other (comment)	Anticipated d/c living situation ☐ Home alone ☐ Home with family/caregivers ☐ Residential care/LTC ☐ Supportive housing ☐ No plan If d/c plan is residential care/LTC, has an application been completed? ☐ Yes ☐ No ☐ LTC resident ☐ Unknown

Reason For Rehabilitation Stay:

Other Medical Conditions:

Risk of Complications: Select One	
Expected 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

Has the patient attended rehab previously for this diagnosis? ☐ Yes ☐ No ☐ Unknown

If yes, please provide name of facility, date of stay, and primary diagnosis:

Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____

Weight _____Height _____

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

Increased confusion at night? ☐ Yes ☐ No

Future surgery scheduled? ☐ Yes ☐ No

If yes, specify type of surgery, date, surgeon's name, and location:

Special Needs – If any boxes are checked please provide details ☐ Open wounds ☐ Infections (list) ☐ IV therapy

☐ Oxygen/Respiratory treatments ☐ Trach ☐ Vent ☐ Pain ☐ Dialysis ☐ 1:1Supervision ☐ Ongoing outpatient medical treatments (i.e.:radiation/chemotherapy)

Details:

Nutrition Needs Select One

TPN Details:

Prior Level of Function Immediately Before Hospital Stay:

Ambulation: Select One	# Feet:
Wheelchair Mobility: Select One Transfers: Select One Grooming/Hygiene: Select One Bathing: Select One Dressing: Select One	
Previously used DME:	

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	☐ Other: Additional Info:

Comments or other pertinent information:

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