carelon

# Initial Long Term Acute Care Facility Authorization Request Form

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

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

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

## INSTRUCTIONS

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

- ☐ This referral form (fully completed – include comments).
- ☐ Hospital H&P (if applicable).
- ☐ Last 2-3 days of physician progress notes.
- ☐ Last 2-3 days of nursing notes.
- ☐ Specialty consultations.
- ☐ Complete list of all current medications including IV antibiotic end date(s).
- ☐ Diagnostics (CT scans / X-ray reports) and most recent lab work.
- ☐ Ventilator Weaning Requests – ventilator flow sheets with all weaning trials.
- ☐ Most recent wound care documentation.

## MEDICAL AND PHYSICAL STATUS

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

| Select Clinical Category: | |
|---|---|
| ☐ Ventilator Management | ☐ Respiratory Complex |
| ☐ Cardiac Complex | ☐ Medically Complex |
| ☐ Wound Complex | |

| Reason For LTACH Request: |
|---|
| |

| Past Medical History/Other Medical Conditions: |
|---|
| |

| Future surgery scheduled ☐Yes ☐No | If yes, specify type of surgery, date, surgeon's name, and location |
|---|---|
| Additional information: | |

| Is there a caregiver identified and able to assist the patient at home? ☐Yes ☐No ☐Unknown<br><br>Previous living situation<br>☐Home alone ☐Home with family/caregivers ☐Supportive housing<br>☐Homeless ☐Unknown ☐Other (comment)<br><br>Planned d/c living situation<br>☐Home alone ☐Home with family/caregivers ☐LTC<br>☐Supportive housing ☐No plan<br><br>If d/c plan is residential care/LTC, has an application been completed?<br>☐Yes ☐No ☐Known to LTC | Does the patient have an advanced directive? ☐Yes ☐No ☐Unknown<br><br>Has hospice or palliative care been consulted?<br>☐Yes ☐No ☐Unknown<br><br>Is there a medical power of attorney?<br>☐Yes ☐No ☐Unknown<br><br>Name and relationship to patient: |
|---|---|

## Planned Treatment Intervention

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

Neurologically stable last 24 hours? ☐Yes ☐No

Mental Status: Baseline _____ Current: Alert & Oriented X _____ Ability to follow commands: _____
Comment:

| 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: ☐1-2x/wk ☐3-4x/wk ☐5x/wk ☐Unknown |
| ☐Occupational therapy to address functional impairment | Anticipated Frequency: ☐1-2x/wk ☐3-4x/wk ☐5x/wk ☐Unknown |
| ☐Speech therapy to address functional impairment | Anticipated Frequency: ☐1-2x/wk ☐3-4x/wk ☐5x/wk ☐Unknown |

RESPIRATORY

| Oximetry: | Vent ☐Yes ☐No | Venti mask/liters: | NC/Liters: | |
|---|---|---|---|---|
| Mode: | Rate: | TV: | PEEP: | FiO2: |
| Dates and Progress of Vent Weaning Attempts? | | | | |

| | | |
|---|---|---|
| ☐ CPAP ☐ BiPAP | How long: | Oxygen saturation response: |
| Tracheostomy: ☐ Yes ☐ No | Date Inserted: | Decannulation trial: |

| | | |
|---|---|---|
| CXR stable/improving? ☐ Yes ☐ No | ☐ Chest Physiotherapy. Frequency: ☐ Oxygen adjustments (based on oximetry). Frequency: ☐ Suctioning. Frequency: Color: Amount: | ☐ Nebulizer treatments: Frequency: |
| Cardiac rhythm/telemetry? ☐ Yes ☐ No | NYHA class <IV? ☐ Yes ☐ No ☐ N/A | Continuous Sedation/Paralytic Infusions? ☐ Yes ☐ No ☐ N/A |
| Current Blood Pressure (last 2-3 days): | | |
| Pain Management and Pain Control: | | |
| Other Lines: chest tubes, drainage device, etc.: | | |
| Additional Information: | | |

IV THERAPY

| IV Medication | Dose | Type of Line (central/picc/etc) | Frequency | Start Date | End Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | |
|---|---|
| Dialysis: ☐ Yes ☐ No | ☐ Acute ☐ Chronic ☐ HD ☐ Access: Peritoneal Frequency: |
| Additional Information: | |

NUTRITION

| | | |
|---|---|---|
| Diet Type | ☐ NPO ☐ TF ☐ TPN ☐ Oral | |
| | Date tube placed: | Date TPN started: |
| Amount of feeding | Duration | |
| For TF - Formula | Route ☐ NG ☐ PEG ☐ J Tube ☐ Dobhoff | |
| Diet | | |
| Additional Information | | |

WOUND CARE

Skin Intact ☐ Yes ☐ No If not intact, answer the remaining questions about the member's wounds/incisions.

Specialty Bed ☐ Yes ☐ No Type:

| Wound/Incision #1: | | |
|---|---|---|
| Stage: Select One | Size: L x W x D (cm) = x x | |
| Description: | | |
| Treatment/Dressings: | Frequency: | |
| Wound Debridement ☐ Y ☐ N Date: | | |
| Wound Vac: ☐ Yes ☐ No | | |

| Wound/Incision #2: | | |
|---|---|---|
| Stage: Choose One | Size: L x W x D (cm) = x x | |
| Description: | | |
| Treatment/Dressings: | Frequency: | |
| Wound Debridement ☐ Yes ☐ No Date: | | |
| Wound Vac: ☐ Yes ☐ No | | |

| Wound/Incision #3: | | |
|---|---|---|
| Stage: Choose One | Size: L x W x D (cm) =_____x_____x _____ | |
| Description: | | |
| Treatment/Dressings: | Frequency: | |
| Wound Debridement ☐ Yes ☐ No Date: | | |
| Wound Vac: ☐ Yes ☐ No | | |

| Wound/Incision #4: | | |
|---|---|---|
| Stage: Choose One | Size: L x W x D (cm) =_____x _____x _____ | |
| Description: | | |
| Treatment/Dressings: | Frequency: | |
| Wound Debridement ☐ Yes ☐ No Date: | | |
| Wound Vac: ☐ Yes ☐ No | | |

Additional Information: