



Initial Inpatient Rehabilitation Facility Authorization Request Form

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986

Questions? Call 844-411-9622

Date of Request:	Standard Retro	Urgent Request: <i>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</i>
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Member Information:	Member Name:	Member ID:	Date of Birth:
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Requesting Rehab Facility Information	Referral Source Information	
Facility Name:	Referral Source Type: <input type="checkbox"/> Hospital SNF IRF	Ordering Physician:
Tax ID:	<input type="checkbox"/> LTACH PhysicianOffice EmergencyDept	Ordering Physician NPI:
NPI:	<input type="checkbox"/> Psychiatric Hosp/Unit	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? <input type="checkbox"/> Y <input type="checkbox"/> 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			
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neurologic Disorder- NOS	<input type="checkbox"/> Fracture of Femur	<input type="checkbox"/> Major Multiple Trauma

<input type="checkbox"/> Spinal Cord Dysfunction	<input type="checkbox"/> Arthritis- Inflammatory or severe degenerative	<input type="checkbox"/> Burns	<input type="checkbox"/> Medically Intensive
<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Knee or Hip Replacement	<input type="checkbox"/> Amputation	<input type="checkbox"/> Other

Is there a caregiver identified and able to assist the patient at home? Yes No Unknown Previous living situation <input type="checkbox"/> Home alone <input type="checkbox"/> Home with family/caregivers <input type="checkbox"/> Residential care/LTC <input type="checkbox"/> Homeless <input type="checkbox"/> Other (comment)	Anticipated d/c living situation <input type="checkbox"/> Home alone <input type="checkbox"/> Home with family/caregivers <input type="checkbox"/> Residential care/LTC <input type="checkbox"/> Supportive housing <input type="checkbox"/> No plan If d/c plan is residential care/LTC, has an application been completed? Yes No LTC resident Unknown
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Reason For Rehabilitation Stay:
Other Medical Conditions:

Risk of Complications:	
Expected Level of Improvement:	Rehabilitation Potential:

Select all the following skilled services the patient will require for post-acute care.	
<input type="checkbox"/> Medical and/or nursing care	Anticipated frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Every other day <input type="checkbox"/> Weekly <input type="checkbox"/> Unknown
<input type="checkbox"/> Physical therapy to address functional impairment	Anticipated Frequency: ___hours/day ___# days/week
<input type="checkbox"/> Occupational therapy to address functional impairment	Anticipated Frequency: ___hours/day ___# days/week
<input type="checkbox"/> Speech therapy to address functional impairment	Anticipated Frequency: ___hours/day ___# days/week

Has the patient attended rehab previously for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Episodes of agitation? <input type="checkbox"/> Yes <input type="checkbox"/> No Increased confusion at night? <input type="checkbox"/> Yes <input type="checkbox"/> 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
TPN Details:

Prior Level of Function Immediately Before Hospital Stay:

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

Current Level of Function:

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

Comments or other pertinent information:
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