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

Initial Inpatient Rehabilitation Facility Authorization 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 Rehab Facility Information	*Referral Source Information*	
Facility Name:	Referral Source Type: ☐ Hospital SNF IRF ☐ LTACH PhysicianOffice EmergencyDept ☐ Psychiatric Hosp/Unit	Ordering Physician:
		Ordering Physician NPI:
NPI:		
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:	
Expected Level of Improvement:	Rehabilitation Potential:

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

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:

CONFIDENTIALITY NOTICE: This fax message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information or may otherwise be protected by law. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by fax and destroy all copies of the original message

© 2023 Carelon Post Acute Solutions