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

Inpatient Rehabilitation Facility Continued Stay 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

Reason For Continued Rehabilitation Stay:
Past Medical History/Other Medical Conditions:

Risk of Complications:	
Expected Overall 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

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

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:

TPN Details:

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	

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? [IF YES] [IF YES] Caregiver ability to provide care: [IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? [IF YES] Has caregiver training been completed? Home Living Environment: # of steps to enter:__________ Rails: Is there a ramp to enter? Bed 1st Floor Bath 1st Floor Is there ability for first floor setup? If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? If yes, Name of Company:	Has a facility been chosen? [IF YES] Name of facility: Has an application been completed? Is it anticipated that a bed/room be available for the patient? Is it anticipated that the facility will be able to provide the level of care needed at discharge? Does patient require an application for Medicaid? Discharge Plan Comment:

Comments or other pertinent information:

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