carelon

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

Initial Long Term Acute Care 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 LTACH Facility Information	*Referral Source Information*	
Facility Name:	Referral Source Type: ☐ Hospital ☐ SNF ☐ IRF ☐ LTACH ☐ Physician Office ☐ Emergency Dept ☐ 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:
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 Previous living situation ☐Home alone ☐Home with family/caregivers ☐Supportive housing ☐Homeless ☐Unknown ☐Other (comment) Planned d/c living situation ☐Home alone ☐Home with family/caregivers ☐LTC ☐Supportive housing ☐No plan If d/c plan is residential care/LTC, has an application been completed? ☐Yes ☐No ☐Known to LTC	Does the patient have an advanced directive? ☐Yes ☐No ☐Unknown Has hospice or palliative care been consulted? ☐Yes ☐No ☐Unknown Is there a medical power of attorney? ☐Yes ☐No ☐Unknown 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: