carelon

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

Long Term Acute Care Hospital 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 LTACH 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:
LTACH Facility Contact Name:	LTACH admission date:	
LTACH Facility Contact Phone:	Anticipated LTACH Discharge date:	*If available, please attach POA/AOR with request*
LTACH 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).
- ☐ LTACH H & P
- ☐ 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 the last four days of 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 Continued LTACH Stay:

Past Medical History/Other Medical Conditions:

Discharge Planning (general):

Previous living situation		Planned d/c living situation	
☐ Home alone	☐ Supportive Housing	☐ Home alone	☐ Supportive Housing
☐ Home with spouse	☐ Homeless	☐ Home with spouse	☐ Homeless
☐ Home with family/caregiver	☐ Unknown	☐ Home with family/caregiver	☐ Unknown
☐ Long Term Care	☐ Other (describe):	☐ Long Term Care	☐ Other (describe):

For discharge plans to return home:

Is there a caregiver identified and able to assist the patient? Select One

[IF YES] Unknown

[IF YES] Caregiver ability to provide care: Select One

[IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? Select One

[IF YES] Has caregiver training been completed? Select One

Home Living Environment:
# of steps to enter:_____ Rails: Select One

Is there a ramp to enter? Select One

Bed 1st Floor Select One

Bath 1st Floor Select One

Is there ability for first floor setup? Select One

If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? Select One

If yes, Name of Company:

For discharge plans to long term care or supportive housing:

Has a facility been chosen? Select One

[IF YES] Name of facility:

Has an application been completed? Select One

Is it anticipated that a bed/room be available for the patient? Select One

Is it anticipated that the facility will be able to provide the level of care needed at discharge? Select One

Does patient require an application for Medicaid? Select One

Discharge Plan Comment:

Future surgery scheduled ☐Yes ☐No	If yes, specify type of surgery, date, surgeon's name, and location

Any Medical Changes since date of last review:

Planned Treatment Interventions

Most recent vitals: Temp: Pulse: RR: BP: O2 sat:

Weight: Height:

Neurologically stable last 24 hours? ☐Yes ☐No

Current: Alert & Oriented x Ability to follow commands:

Current Level of Function:

Ambulation: Select One	# Feet
Wheelchair Mobility: Select One	
Transfers: Select One	
Grooming/Hygiene: Select One	
Bathing: Select One	
Dressing: Select One	
Toileting: Select One	
DME needed: ☐ wheelchair ☐ walker ☐ cane ☐ bedside commode ☐ shower chair ☐ Hoyer lift ☐ brace ☐ other	
Additional Info:	

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:		
Cardiac Rhythm/telemetry: ☐ Yes ☐ No	NYHA class <IV? ☐ Yes ☐ No ☐ N/A	Continuous Sedation/Paralytic Infusions? ☐ Yes ☐ No ☐ N/A		
Other lines: chest tubs, drainage device, etc.:				
Pain Management and Pain Control:				
Additional Information:				

IV Therapy

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

Dialysis: ☐ Yes ☐ No	☐ Acute ☐ Chronic ☐ HD ☐ Peritoneal Frequency: Access:
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 Type:

☐ No

Wound/Incision #1:	Wound/Incision #2:
Location:	Location:
Stage: Select One	Stage: Select One
Size: LxWxD (cm)____x_____x_____	Size: LxWxD (cm)____x_____x_____
Description:	Description:
Treatment/Dressings:	Treatment/Dressings:
Wound Debridement: ☐ Yes ☐ No Date:	Wound Debridement: ☐ Yes ☐ No Date:
Frequency:	Frequency:
Wound Vac: ☐ Yes ☐ No	Wound Vac: ☐ Yes ☐ No
Wound/Incision #3:	**Wound/Incision #4:**
Location:	Location:
Stage: Select One	Stage: Select One
Size: LxWxD (cm)____x_____x_____	Size: LxWxD (cm)____x_____x_____
Description:	Description:
Treatment/Dressings:	Treatment/Dressings:
Wound Debridement: ☐ Yes ☐ No Date:	Wound Debridement: ☐ Yes ☐ No Date:
Frequency:	Frequency:
Wound Vac: ☐ Yes ☐ No	Wound Vac: ☐ Yes ☐ No

Additional Information: