



Utilization Management
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

HealthLink Acute Inpatient Rehabilitation Review

Date: _____ Notification # _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.

Facility or Agency Information

Name _____
Address _____
Phone No. _____ Fax No. _____

Patient Information

Patient's Name _____
ID Number _____ Patient's DOB: _____
Address _____
Daytime Phone No. _____ Height: _____ Weight: _____

Attending Physician Information

Physician Name _____
Group Practice Name _____
Address _____
Phone No. _____ Fax No. (Required) _____
TIN _____

Admission Information

Case Manager's Name: _____ Phone: _____
Admit Date: _____

Treatment Information

Diagnosis _____
Procedure _____ Procedure Date _____
Referring MD: _____ Phone: _____
Estimated Length of Stay: _____
Past Medical History: _____

Prior Level of Function: _____
Will the patient be receiving Intravenous Medications YES NO

If **yes**, please specify: _____

Current Ambulating Distance: _____
Assistive Devices Required for Ambulation: _____
Is the Patient Full Weight Bearing YES NO

If **no**, please specify: _____

Is the patient alert and oriented to person, place, and time YES NO

If **no**, please specify: _____
Is the member able to tolerate three (3) hours of therapy per day YES NO

Current Level of function/ Level of Assistance Required to Complete Tasks/Functions:

(Please select the correct level of function for each task/function listed below)

Task/Function	Dependent	Max Assist	Mod Assist	Min Assist	Contact Guard	Standby Assist	Supervision	Independent
Transfers								
Bed to chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit to stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tub/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding/Nutrition								
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing								
Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting								
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing								
Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication								
Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem-Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Home Status/Social Support: _____

Treatment Plan (include frequency of PT, OT, and ST): _____

Goals:

Short-Term Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Long-Term Goals:

1. _____
2. _____
3. _____
4. _____
5. _____

Discharge Information

Discharge Date: _____

Discharge Plans: _____

Anticipated Discharge Needs: SNF HHC HI* DME* Outpatient PT HOSPICE

*Preferred Providers available

Patient Emergency Contact: _____ Phone: _____

Contact Information

Contact Person _____
Phone No. _____ Fax No. _____

Staff Signature/Title: _____ Date: _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.