



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Long Term Acute Care (LTAC) Admissions Precertification Review

Date: _____ Reference #: _____ (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.

Provider Information

Provider Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 ID Number: _____
 Patient DOB: _____
 Address: _____
 Phone: _____

Primary Physician Information (Treating Physician in LTAC)

Primary Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Treatment Information

Primary Diagnosis: _____
 Diagnosis (ICD-9) Code: _____
 Secondary or other diagnosis patient is being treated for:

Recent Procedure(s): _____
 Procedure (ICD-9) Code(s): _____
 Procedure Date(s): _____
 Estimated Length of Stay: _____
 Pertinent Medical History: (submit history, physical and/or hospital discharge summary with this form) _____

Is the member medically stable and ready for transfer? YES NO

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.

Has the individual's acute illness changed such that intensive or acute hospital care is no longer required but chronic complex medical conditions remain? YES NO

Are the services required not available or can the condition be more appropriately managed in a setting other than the current acute care setting where the member is hospitalized? YES NO

Are there clearly documented goals that can be reasonably obtained by the plan of care? YES NO

Does the patient have:

A condition(s) requiring prolonged ventilator weaning YES NO

If yes, please describe weaning attempts and current ventilator settings _____

Chronic renal failure requiring ongoing dialysis which complicates other medical conditions requiring intense daily medical care YES NO

If yes document type of dialysis and planned dialysis schedule _____

Complex Medical Regimens (i.e. IV meds, TPN, transfusions, amphi B) YES NO

If yes, please supply the following information:

IV Drugs	J Code	Dosage	Frequency	Start Date	End Date

Frequent Diagnostics YES NO

If yes, list all tests and frequency ordered (labs, x-rays, imaging) _____

Intensive Respiratory Care YES NO

If yes, describe treatment ordered and frequency _____

Telemetry or Pulmonary Monitoring YES NO

If yes, describe treatment ordered and frequency _____

Open Wounds Requiring Intensive Treatment YES NO

If yes, please describe size, stage of wounds, treatment prescribed, and frequency of treatment _____

Parenteral Pain Management Requirements YES NO

If yes, document treatment ordered and frequency _____

Physical, Occupational, or Speech Therapy Requirement YES NO

If yes, document assistance for below ADLS:

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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	Not Assessed	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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>

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

Goals

Short-Term Goals:

1. _____
2. _____
3. _____

Discharge Information

Anticipated Discharge Date: _____

Anticipated Discharge Plans: _____

Anticipated Discharge Needs: Rehab SNF HHC* Home Infusion*

Preferred Providers available DME Outpatient PT Outpatient OT HOSPICE

Patient Emergency Contact: _____ Phone: _____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____

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