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-10) Code: _____

Secondary or other diagnosis patient is being treated for:

_____

_____

_____

Recent Procedure(s): _____

Procedure (ICD-10) 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, ampho 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:

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	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit to stand	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toilet	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tub/Shower	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feeding/Nutrition									
Feeding	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bathing									
Upper Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toileting									
Toileting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dressing									
Upper Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication									
Comprehension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Expression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social Interaction	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problem-Solving	☐	☐	☐	☐	☐	☐	☐	☐	☐

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: _____