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

Acute Rehab Facility Admissions Precertification Review

Date: _____ Reference #: _____(provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference 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: _____

Fax: _____

Patient Information

Patient Name: _____

ID Number: _____

Patient DOB: _____

Address:_____

Phone: _____

Admitting Physician Information

Physician Name: _____

Group Practice Name: _____

Address: _____

Phone: _____

Fax: _____

TIN: _____

Admission Information

Case Manager Name: _____

Phone: _____

Admission Date: _____

Treatment Information

Primary Diagnosis: _____

Diagnosis (ICD-10) Code: _____

Primary Procedure: _____

Procedure (ICD-10) Code: _____

Procedure Date: _____

Referring MD: _____

Phone: _____

Estimated Length of Stay: _____

Pertinent Medical History: (submit history, physical and/or hospital discharge summary with this form)_____

_____

_____

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	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	☐	☐	☐	☐	☐	☐	☐	☐	☐

Home Status/Social Support/Potential Discharge Barriers: _____

_____

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

_____

_____

Goals

Short-Term Goals:

1. _____
2. _____
3. _____

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.

Long-Term Goals:

1. _____
2. _____
3. _____

Discharge Information

Discharge Date: _____

Discharge Plans: _____

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

**Preferred Providers available*

Patient Emergency Contact:_____ Phone:_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____