

INITIAL LONG TERM ACUTE CARE HOSPITAL AUTHORIZATION REQUEST FORM

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986

Questions? Call 844-411-9622

**FOR FASTER AUTHORIZATION,
PLEASE VISIT:
<https://portal.mynexuscare.com>**

Date of Request:	<input type="checkbox"/> Standard <input type="checkbox"/> Retro	<input type="checkbox"/> Urgent Request <i>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</i>
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Member Information:		
Member Name:	Member ID:	Date of Birth:

Requesting LTACH Facility Information	Referral Source Information	
Facility Name:	Referral Source Type: <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> IRF <input type="checkbox"/> LTACH <input type="checkbox"/> Physician Office <input type="checkbox"/> Emergency Dept	Ordering Physician:
NPI:	<input type="checkbox"/> Psychiatric Hosp/Unit	Ordering Physician NPI:
Phone:	Referral Source:	Date of Onset of Illness/Injury:
Fax:	Referral Source NPI:	Hospital admission date:
LTACH Facility Contact Name:	Referral Source Contact Name:	Anticipated LTACH Admit Date:
LTACH Facility Contact Phone:	Referral Source Contact Phone:	Is member currently in your facility? <input type="checkbox"/> Y <input type="checkbox"/> N
LTACH Facility Contact Fax:		

INSTRUCTIONS

Submission **MUST** include the following as part of your referral package:

- This referral form (fully completed – include comments).
- Hospital H&P (if applicable).
- 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 all weaning trials.
- Most recent wound care documentation.

MEDICAL AND PHYSICAL STATUS

Admitting ICD-10 Code(s)			
1 (Primary)	2	3	4

Select Clinical Category:
<input type="checkbox"/> Ventilator Management <input type="checkbox"/> Respiratory Complex <input type="checkbox"/> Cardiac Complex <input type="checkbox"/> Medically Complex <input type="checkbox"/> Wound Complex

Reason For LTACH Request:
Past Medical History/Other Medical Conditions:

Future surgery scheduled <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, specify type of surgery, date, surgeon's name, and location
Additional information:	

Is there a caregiver identified and able to assist the patient at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Previous living situation <input type="checkbox"/> Home alone <input type="checkbox"/> Home with family/caregivers <input type="checkbox"/> Supportive housing <input type="checkbox"/> Homeless <input type="checkbox"/> Unknown <input type="checkbox"/> Other (comment) _____ Planned d/c living situation <input type="checkbox"/> Home alone <input type="checkbox"/> Home with family/caregivers <input type="checkbox"/> LTC <input type="checkbox"/> Supportive housing <input type="checkbox"/> No plan If d/c plan is residential care/LTC, has an application been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Known to LTC	Does the patient have an advanced directive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Has hospice or palliative care been consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is there a medical power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Name and relationship to patient:
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Planned Treatment Intervention

Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____ Weight _____ Height _____ Neurologically stable last 24 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Status: Baseline _____ Current: Alert & Oriented X _____ Ability to follow commands: _____ Comment:

Select all the following skilled services the patient will require for post-acute care.	
<input type="checkbox"/> Medical and/or nursing care	Anticipated frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Every other day <input type="checkbox"/> Weekly <input type="checkbox"/> Unknown
<input type="checkbox"/> Physical therapy to address functional impairment	Anticipated Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown
<input type="checkbox"/> Occupational therapy to address functional impairment	Anticipated Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown
<input type="checkbox"/> Speech therapy to address functional impairment	Anticipated Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown

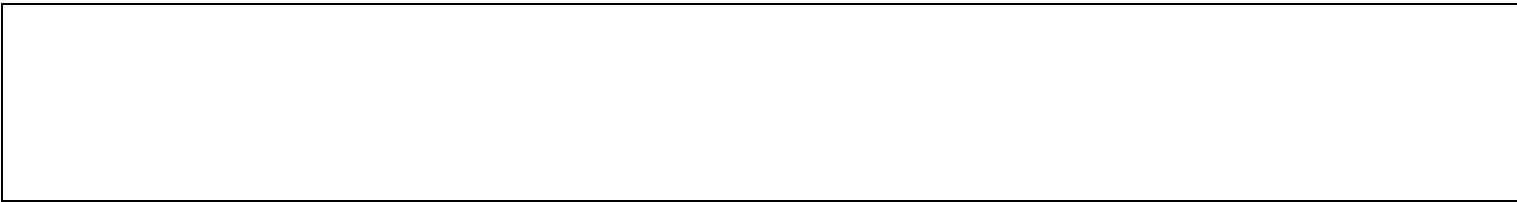
RESPIRATORY

Oximetry:	Vent <input type="checkbox"/> Yes <input type="checkbox"/> No	Venti mask/liters:	NC/Liters:	
Mode:	Rate:	TV:	PEEP:	FiO2:
Dates and Progress of Vent Weaning Attempts?				
<input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP	How long:	Oxygen saturation response:		
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Inserted:	Decannulation trial:		

WOUND CARE

Skin Intact <input type="checkbox"/> Yes <input type="checkbox"/> No If not intact, answer the remaining questions about the member's wounds/incisions.		
Specialty Bed <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____		
Wound/Incision #1:		
Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Not able to be staged	Size: L x W x D (cm) = _____ x _____ x _____	
Description:		
Treatment/Dressings:		Frequency:
Wound Debridement <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:
Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Wound/Incision #2:		
Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Not able to be staged	Size: L x W x D (cm) = _____ x _____ x _____	
Description:		
Treatment/Dressings:		Frequency:
Wound Debridement <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:
Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Wound/Incision #3:		
Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Not able to be staged	Size: L x W x D (cm) = _____ x _____ x _____	
Description:		
Treatment/Dressings:		Frequency:
Wound Debridement <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:
Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Wound/Incision #4:		
Stage: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Not able to be staged	Size: L x W x D (cm) = _____ x _____ x _____	
Description:		
Treatment/Dressings:		Frequency:
Wound Debridement <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:
Wound Vac: <input type="checkbox"/> Yes <input type="checkbox"/> No		

Additional Information:



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