myNEXUS

INITIAL INPATIENT REHABILITATION FACILITY AUTHORIZATION REQUEST FORM

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

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986
Questions? Call 844-411-9622

Date of Request:	☐ Standard ☐ Retro	☐ Urgent Request: *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*

Member Information:

Member Name:	Member ID:	Date of Birth:

Requesting Rehab Facility Information	*Referral Source Information*	
Facility Name:	Referral Source Type: ☐Hospital ☐SNF ☐IRF ☐LTACH ☐Physician Office ☐Emergency Dept ☐Psychiatric Hosp/Unit	Ordering Physician:
		Ordering Physician NPI:
NPI:		
Tax ID:	Referral Source:	Date of Onset of Illness/Injury:
Phone:	Referral Source NPI:	Hospital admission date:
Fax:	Referral Source Contact Name:	Anticipated Rehab Admit Date:
IRF Facility Contact Name:	Referral Source Contact Phone:	Is member currently in your facility? ☐Y ☐N
IRF Facility Contact Phone:		
IRF Facility Contact Fax:		

INSTRUCTIONS

Submission

MUST include the following as part of your referral package:

□ All pages of this referral form (fully completed – include comments)
□ Hospital H&P (if applicable)
□ 1-2 days of most recent physician notes
□ 1-2 days of most recent nursing notes
□ 1-2 days of most recent wound care notes, if applicable
□ Specialty consultations
□ Therapist assessment/ current progress notes that provide relevant supplemental information (e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST
□ Diagnostics (CT scans / X-ray reports) and most recent lab work
□ Current medication list/record
□ Preadmission assessment (optional)

Please attest to the following: (NOTE: All the following requirements must be met for request to meet medical necessity criteria)

☐ The patient is medically stable with medical or surgical comorbidities that do not require ongoing acute medical attention.
☐ There is a reasonable expectation that the requested level of skilled care is necessary to achieve therapeutic goals.
☐ Improvement is expected in a reasonable and predictable period of time.
☐ The patient's condition has reasonable potential to respond favorably to skilled therapies, medical, and/or nursing care.
☐ The patient is physically and mentally capable of participating in 3 hours of therapy, 5x/week, or at least 15 hours of intensive rehabilitation within a 7-day consecutive calendar day or period.

MEDICAL AND PHYSICAL STATUS

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

Clinical Category			
☐Stroke	☐ Neurologic Disorder- NOS	☐ Fracture of Femur	☐ Major Multiple Trauma
☐Spinal Cord Dysfunction	☐ Arthritis- Inflammatory or severe degenerative	☐ Burns	☐Medically Intensive
☐ Brain Injury	☐ Knee or Hip Replacement	☐ Amputation	☐Other

Is there a caregiver identified and able to assist the patient at home? ☐Yes☐No☐Unknown Previous living situation☐Home alone☐Home with family/caregivers ☐Residential care/LTC☐Homeless☐Other (comment)	Anticipated d/c living situation☐Home alone ☐Home with family/caregivers ☐Residential care/LTC☐Supportive housing ☐No plan If d/c plan is residential care/LTC, has an application been completed? ☐Yes☐No☐LTC resident☐Unknown

Reason For Rehabilitation Stay:

Other Medical Conditions:

Risk of Complications: ☐ Low ☐ Moderate ☐High	
Expected Level of Improvement: ☐Independent/Mod I ☐ Supervision☐CGA☐MINA☐MODA☐ MAXA☐DEP☐Unknown	Rehabilitation Potential: ☐ Poor ☐Fair ☐Good ☐Excellent

Select all the following skilled services the patient will require for post-acute care.	
☐Medical and/or nursing care	Anticipated frequency: ☐Daily ☐Every other day ☐Weekly ☐Unknown
☐Physical therapy to address functional impairment	Anticipated Frequency: ____hours/day ____# days/week
☐Occupational therapy to address functional impairment	Anticipated Frequency: ____hours/day ____# days/week
☐Speech therapy to address functional impairment	Anticipated Frequency: ____hours/day ____# days/week

Has the patient attended rehab previously for this diagnosis? ☐Yes ☐No ☐Unknown
If yes, please provide name of facility, date of stay, and primary diagnosis:
Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____ Weight _____ Height _____ Alert and oriented X _____ Able to follow commands?☐Yes ☐No Episodes of agitation?☐Yes ☐No Increased confusion at night?☐Yes ☐No
Future surgery scheduled?☐Yes☐No If yes, specify type of surgery, date, surgeon's name, and location:
Special Needs – If any boxes are checked please provide details ☐Open wounds☐Infections (list)☐IV therapy ☐Oxygen/Respiratory treatments ☐Trach☐Vent☐ Pain☐ Dialysis ☐1:1 Supervision☐Ongoing outpatient medical treatments (i.e.: radiation/chemotherapy) Details:
Nutrition Needs☐Dysphagic diet☐NPO☐PEG ☐NG ☐TPN Details:

Prior Level of Function Immediately Before Hospital Stay:

Ambulation:	# Feet:	☐ Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐ MODA ☐ MAXA ☐DEP ☐Unknown
Wheelchair Mobility:		☐ Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐ MODA ☐ MAXA ☐DEP ☐Unknown
Transfers:		☐ Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐ MODA ☐ MAXA ☐DEP ☐Unknown
Grooming/Hygiene:		☐ Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐ MODA ☐ MAXA ☐DEP ☐Unknown
Bathing:		☐ Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐ MODA ☐ MAXA ☐DEP ☐Unknown
Dressing:		☐ Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐ MODA ☐ MAXA ☐DEP ☐Unknown
Previously used DME:		

Current Level of Function:

Date of Current Therapy Status:		
Weight Bearing Status:		☐FWB ☐WBAT ☐PWB ☐NWB ☐Unknown
Ambulation:	# Feet:	☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Wheelchair Mobility (if applicable):		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Bed Mobility:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Transfers:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Stairs:	# Stairs:	☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Feeding:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Grooming/Hygiene:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Bathing:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Dressing:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
Toileting:		☐Independent/Mod I ☐Supervision ☐CGA ☐MINA ☐MODA ☐ MAXA ☐DEP ☐ Unknown
DME Needed		☐ W/C ☐Walker ☐Cane ☐ Brace ☐Bedside Commode ☐Bath/Shower Chair ☐ Brace ☐ Other:

Comments or other pertinent information: