myNEXUS

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:	☐ 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 LTACH 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 LTACH Admit Date:
LTACH Facility Contact Name:	Referral Source Contact Phone:	Is member currently in your facility? ☐ Y ☐ N
LTACH Facility Contact Phone:		
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:	
☐ Ventilator Management	☐ Respiratory Complex
☐ Cardiac Complex	☐ Medically Complex
☐ Wound Complex	

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

Future surgery scheduled ☐Yes ☐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? ☐Yes☐No☐Unknown Previous living situation ☐ Home alone ☐Home with family/caregivers ☐Supportive housing ☐ Homeless ☐Unknown ☐Other (comment)_____ Planned d/c living situation ☐Home alone ☐Home with family/caregivers ☐LTC ☐Supportive housing ☐No plan If d/c plan is residential care/LTC, has an application been completed? ☐Yes☐No☐Known to LTC	Does the patient have an advanced directive?☐ Yes ☐No ☐Unknown Has hospice or palliative care been consulted? ☐Yes ☐No ☐Unknown Is there a medical power of attorney? ☐Yes ☐No ☐Unknown Name and relationship to patient:

Planned Treatment Intervention

Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2 sat _____ Weight _____ Height _____

Neurologically stable last 24 hours? ☐Yes ☐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.	
☐ Medical and/or nursing care	Anticipated frequency: ☐Daily ☐Every other day ☐Weekly ☐Unknown
☐ Physical therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐3-4x/wk ☐ 5x/wk ☐ Unknown
☐ Occupational therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐3-4x/wk ☐ 5x/wk ☐ Unknown
☐ Speech therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐3-4x/wk ☐ 5x/wk ☐ Unknown

RESPIRATORY

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

CXR stable/improving? ☐Yes☐No	☐ **Chest Physiotherapy.** Frequency: _____ ☐ **Nebulizer treatments:** Frequency: _____ ☐ **Oxygen adjustments** (based on oximetry). Frequency: _____ ☐ **Suctioning.** Frequency: _____ Color: _____ Amount: _____	
Cardiac rhythm/telemetry? ☐Yes☐No	NYHA class <IV?☐Yes☐No☐N/A	Continuous Sedation/Paralytic Infusions?☐Yes☐No☐N/A
Current Blood Pressure (last 2-3 days):		
Pain Management and Pain Control:		
Other Lines: chest tubes, drainage device, etc.:		
Additional Information:		

IV THERAPY

IV Medication	Dose	Type of Line (central/picc/etc)	Frequency	Start Date	End Date

Dialysis: ☐Yes ☐No	☐Acute	☐Chronic	☐HD	☐Peritoneal
	Frequency:		Access:	
Additional Information:				

NUTRITION

Diet Type	☐NPO☐TF☐TPN☐Oral	
	Date tube placed:	Date TPN started:
Amount of feeding	Duration	
For TF - Formula	Route ☐ NG ☐PEG ☐J Tube☐ Dobhoff	
Diet		
Additional Information		

WOUND CARE

Skin Intact ☐Yes ☐No If not intact, answer the remaining questions about the member's wounds/incisions.

Specialty Bed ☐Yes ☐No Type:

Wound/Incision #1:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _____x _____x _____	
Description:		
Treatment/Dressings:	Frequency:	
Wound Debridement ☐Yes ☐No Date:		
Wound Vac: ☐Yes ☐No		

Wound/Incision #2:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _____x _____x _____	
Description:		
Treatment/Dressings:	Frequency:	
Wound Debridement ☐Yes ☐No Date:		
Wound Vac: ☐Yes ☐No		

Wound/Incision #3:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _____x _____x _____	
Description:		
Treatment/Dressings:	Frequency:	
Wound Debridement ☐Yes ☐No Date:		
Wound Vac: ☐Yes ☐No		

Wound/Incision #4:		
Stage: ☐1 ☐2 ☐3 ☐4 ☐Not able to be staged	Size: L x W x D (cm) = _____x _____x _____	
Description:		
Treatment/Dressings:	Frequency:	
Wound Debridement ☐Yes ☐No Date:		
Wound Vac: ☐Yes ☐No		

Additional Information: