

Passport by Molina Healthcare Long Term Acute Care Hospital (LTACH)

Admission request

Member Name:	DOB:	ID:
Provider Name:	Contact name:	Transfer date to LTACH:
Anticipated LOS / DC:	DC plan:	

Expectation that this patient will require a 25-day length of stay? _____

This patient is stable for transfer to LTACH, as evidenced by:

Hypotension absent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiovascular status acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Stable chest finding? <input type="checkbox"/> Yes <input type="checkbox"/> No
Renal function acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain adequately managed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Acute, severe or unstable neurological abnormalities? <input type="checkbox"/> Yes <input type="checkbox"/> No
Acute, significant hepatic dysfunction? <input type="checkbox"/> Yes <input type="checkbox"/> No	Active bleeding or unstable disorders of hemostasis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Intake acceptable? <input type="checkbox"/> Yes <input type="checkbox"/> No
Isolation required? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Type:	Long-term enteral feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Formula, Rate, Frequency & Duration	TPN / Lipids? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Rate, Frequency & Duration
Feeding tube and/or central line? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	Other:

Please list all LTACH services to be provided

<p>IV ANTIBIOTICS: Medication name, dose, frequency, length of therapy/end date, reason for IV antibiotics. Type of line, central, Peripheral intravenous line:</p>	<p>VENT: Settings, weaning trials, suctioning frequency, nebulizer frequency. Trach specifics:</p>
<p>WOUND CARE: List all wounds inclusive of: location, size, description and care for each wound. Include the length of time to complete each wound(s) care procedure:</p>	<p>REHAB SERVICES: Provide each therapy discipline member will receive, inclusive of hours/day, days/week for each therapy. Include prior and current level of function:</p>
<p>LABS & DIAGNOSTICS: Frequency/Type:</p>	<p>CONTINUOUS MONITORING: Examples: Cardiac/Telemetry; Pulse Oximetry; 1:1 Sitter; Restraints, etc.:</p>
<p>NUTRITION: Tube feeds, TPN/Lipids listed above. Type of PO intake/diet:</p>	<p>DAILY PHYSICIAN VISITS: List all specialties that will follow at LTACH, inclusive of visit frequency:</p>
<p>OTHER IV MEDICATIONS: Med, Dose, Frequency (routine & PRN):</p>	<p>OTHER:</p>

Multidisciplinary assessment completed and documented (ideally, including Palliative Care), and supports expectation that this patient will benefit from, and improve with a LTACH program? Describe:

To expedite the review process:

Limit the number of pages of documentation you submit with your auth request to only the minimum necessary clinical information. This includes: Recent MD progress notes; any changes in condition from prior review (I.E. Labs, Physical Findings); Procedure(s) performed; Most recent therapy notes – intake status and medication list.

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.