Louisiana

Explanation of Admission and Recertification Request Form

(Required for all Rehab, SNF, LTAC admits)

Providers must request authorization for initial admissions and recertification of admissions for rehabilitation centers (rehab), skilled nursing (SNF) and long term acute care (LTAC) services. Providers are encouraged to complete an **Admission and Recertification Request Form**, which is part of this guide. The form is available online at www.bcbsla.com/providers.

1 Please check the box that best describes your request.

Please Choose Request Type:

❑ Admission Request

Admitting from: ❑ Home ❑ Hospital

❑ Recertification Request

Admission Request is a request for authorization for a patient initially being admitted to a facility for treatment. Please specify if patient is being admitted from home or a hospital.

Recertification Request is an extension request of the initial admission authorization. This request must be within 24-hours prior to expiration of approved admission period.

2 Please check the type of admission for your request.

Please Choose One:

Admission Type: ❑ Inpatient Rehab Day Rehab: ❑ Half ❑Full ❑ Skilled Nursing ❑ LTAC

Inpatient Rehab
Comprehensive array of restoration services for the physically-disabled and all support services necessary to help patients attain their maximum functional capacity

Day Rehab
A program that provides greater than one (1) hour of Rehabilitative Care, upon discharge from an inpatient admission

Skilled Nursing Facility
Skilled nursing and/or rehabilitation services to patients who need a skilled level of medical care

LTAC
Nursing care and related services for individuals who require medical, nursing, rehabilitation or sub-acute care services for an extended period of time

3 **Member Information:** Please provide the member's name, date of birth and Blue Cross member identification number. If the member also has other insurance, please include other insurance coverage carrier's name and policy number. *(All information should be exactly as it appears on the member's ID card, including any prefixes or suffixes.)*

4 **Requestor Information:** Please provide the admitting facility's name and NPI number along with the name and phone number of the key contact person at the facility. Also provide the admitting physician's first and last name and NPI number as well as the name and phone number of the key contact person for the admitting physician's office.

5 **Clinical Information:** Please provide the admitting facility's name and NPI number along with the name and phone number of the key contact person at the facility. Also provide the admitting physician's first and last name and NPI number as well as the name and phone number of the key contact person for the admitting physician's office.

6 **Discharge Plan:** Please provide applicable clinical information as requested on the form (front and back). Please provide any current physical, occupational and speech therapy notes that may apply.

7 Once you have completed the form, **please fax to 1-800-821-2740, ATTN: Utilization Management**. If you have any questions, please contact our Utilization Management department at 1-800-523-6435.

Louisiana

Admission and Recertification Request

(Required for all Rehab, SNF, LTAC admits)

Fax: 1-800-821-2740

Please Choose One:

❑ Admission Request
Admitting from: ❑ Home ❑ Hospital

❑ Recertification Request

Submit all Recertification Requests at least 24 hours prior to end of approval period.

Date Submitted: _____

Use this form for admissions and recertifications for rehabilitation centers (rehab), skilled nursing (SNF) and long term acute care (LTAC) services.

Submit form to obtain authorization. Additional documentation should be attached only if it provides information not on this form pertinent to the review request. Do not attach or send patient's entire medical record. All items must be legible and properly completed.

ADMISSION TYPE:

(Please Choose Only One) ❑ Inpatient Rehab Day Rehab: ❑ Full ❑ Half ❑ Skilled Nursing ❑ LTAC

MEMBER INFORMATION:

Last Name: _____ First Name: _____ MI:__ DOB: _____ Member ID Number: _____

Other Insurance Coverage Carrier: _____

ID number: _____

Medicare days exhausted: ❑ Yes ❑ No Date exhausted: _____

REQUESTOR INFORMATION:

Admitting Facility Name: _____ Facility NPI: _____ Location: _____

Contact Name: _____ Contact Ph. Number: _____ Fax Number: _____

Admitting Physician Name (First and Last): _____ Physician NPI: _____

Contact Name: _____ Contact Ph. Number: _____

CLINICAL INFORMATION: *(check all that apply)*

- ❑ Medically stable for transfer
- ❑ Minimum of one MD visit per day
- ❑ Comorbids stabilizing
- ❑ Expectation of at least 25 days of continued care
- ❑ Frequent diagnostic testing including clinical assessment, laboratory and imaging
- ❑ Requires more intensive service than can be offered (or patient has failed) at lower levels of care

Admission Date: _____ Estimated Length of Stay: _____ Request Level of Care: _____

Admission Diagnosis code(s): _____

_____

Presenting Signs/Symptoms or Clinical Status: _____

_____

_____

Admission Goals/Treatment Plan: _____

_____

_____

ADL'S (FIM SCORES)

_____ Bed Mobility _____ Sit to Stand _____ Supine to Sit

_____ Bathing _____ UE Dress _____ LE Dress

_____ Swallowing _____ Transfers _____ Bowel/Bladder

_____ Ambulation _____ feet

Mental Status

Oriented ❑ Yes ❑ No

Confused ❑ Yes ❑ No

Follows Commands ❑ Yes ❑ No

Other (please specify): _____

~over~

Respiratory Status/Treatments

- Continued requirement for mechanical ventilation after more than 3 weeks with more than 2 weaning failures in acute hospital ❑ Trach ❑ Chest Tube
- Requires ventilator and respiratory management at least every 4 hours

Vent Settings: _____

O2 Requirements: _____

Nebulizer tx's: _____

Wounds

- Extensive wounds requiring daily assessment, drain management, debridement or complex wound care
- Drains

Wound Care – type of wound(s): _____

Location of wound(s): _____

Descriptions of wound(s): _____

Frequency of wound care: _____

Diet

- Diet: ❑ Oral ❑ NG Tube ❑ Gastric Tube

Other

IV Fluids/TPN: _____

IV Medications: _____

PO Medications: _____

Procedures: _____

_____

EKG/EEG: _____

Lab Results: _____

_____

Radiology: _____

_____

DISCHARGE PLAN:

- ❑ Home alone
- ❑ Home with home health
- ❑ Home with DME
- ❑ Home with Outpatient Services
- ❑ Rehab
- ❑ Skilled Nursing Facility
- ❑ Nursing Home
- ❑ Hospice

Potential barriers to discharge plan: _____

Additional Comments/Notes: _____

_____

Upon discharge, supply caregiver information:

Name: _____

Contact Information: _____

Fax completed form to 1-800-821-2740, ATTN: Utilization Management