PRIOR AUTHORIZATION for LONG TERM ACUTE CARE (LTAC) HOSPITALIZATION

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Facility Name:			Facility Address:		
Facility NPI #:	**Facility Tax ID #:**	**Facility Contact Person:**	**Phone:** ( )	**Fax:** ( )	**Email:**
Case Manager:	**Phone:** ( )		**Facsimile:** ( )	**Email:**	

Referral Source (*Be specific*)_____ ☐ **Transfer from Outside Facility** (***Name of Facility***_____)

Section III: CLINICAL INFORMATION

A. ☐ **Initial Request**

Admit Date_____ **Estimated length of stay** _____

Initial # of Days being Requested_____

B. ☐ **Concurrent Review**

Admit Date_____ **Target Discharge Date** _____

Additional # of Days being Requested_____

C. Primary Diagnosis/ICD-10 Code	D. Secondary Diagnosis/ICD-10 Code	E. Date of Surgery/Onset of Illness	F. Type of Surgery

G. Level of Function prior to Surgery / Illness

H. Use of Assist Device (s) prior to Surgery / Illness

I. Home Environment/Living Arrangement

Single or Multi-Level_____ Type of Residence (*please check*) ☐ Apartment ☐ House ☐ Condo/Townhome ☐ Other_____

Of steps to enter the home_____ /Handrail ☐ Yes ☐ No # Of steps within the home_____ /Handrail ☐ Yes ☐ No Elevator Access: ☐ Yes ☐ No

Bedroom level_____ Bathroom level_____ Kitchen level_____ Does the patient live alone? ☐ Yes ☐ No

J. INITIAL LTAC Needs/Functional Status: **Answer/check if applicable & use minimum, moderate, maximum, contact guard assist, standby assist designation.*

Date_____ IV Therapy_____ IV Access_____

Oxygen Therapy FIO2 % / liters per minute_____ O2 Delivery Device_____ Ventilator Settings_____ ☐ ETT ☐ Tracheostomy

Wound Location/Measurement_____ Length (cm) _____ Width (cm) _____ Depth (cm) _____

Wound Care Frequency_____ Wound VAC (NPWT)? ☐ No ☐ Yes Other drain(s)/location_____

Cognition_____ Bed Mobility_____ Transfers_____ Activity Tolerance_____ Balance_____ Strength_____

Gait_____ Gait Distance_____ Gait Assist Device _____ Stairs_____ # of steps patient can do_____

Feeding_____ Diet _____ Enteral Feeding? ☐ No ☐ Yes (*Type of feeding tube*_____)

GI/GU Catheter/Drainage Devices (*check all that apply*) ☐ Colostomy ☐ Foley ☐ Hemodialysis ☐ Ileostomy ☐ Nephrostomy ☐ Suprapubic ☐ Urostomy

K. CURRENT LTAC Needs/Functional Status: **Answer/check if applicable & use minimum, moderate, maximum, contact guard assist, standby assist designation.*

Date_____ IV Therapy_____ IV Access_____

Oxygen Therapy FIO2 % / liters per minute_____ O2 Delivery Device_____ Ventilator Settings_____ ☐ ETT ☐ Tracheostomy

Wound Location/Measurement_____ Length (cm) _____ Width (cm) _____ Depth (cm) _____

Wound Care Frequency_____ Wound VAC (NPWT)? ☐ No ☐ Yes Other drain(s)/location_____

Cognition_____ Bed Mobility_____ Transfers_____ Activity Tolerance_____ Balance_____ Strength_____

Gait_____ Gait Distance_____ Gait Assist Device _____ Stairs_____ # of steps patient can do_____

Feeding_____ Diet _____ Enteral Feeding? ☐ No ☐ Yes (*Type of feeding tube*_____)

GI/GU Catheter/Drainage Devices (*check all that apply*) ☐ Colostomy ☐ Foley ☐ Hemodialysis ☐ Ileostomy ☐ Nephrostomy ☐ Suprapubic ☐ Urostomy

L. Additional Skilled Needs / Comments

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

**** Please fax completed form and medical records to 801-366-7449.***