PRIOR AUTHORIZATION for INPATIENT REHABILITATION and SKILLED NURSING FACILITY

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:**	

Type of Admission: (*Please check*)

☐ **Direct Admit from Home** ☐ **Transfer from Outside Facility** (***Name of Facility***: _____)

Section III: CLINICAL INFORMATION

☐ **Initial Request**

Admit Date: _____ **Estimated length of stay:** _____

Initial # of Days being Requested: _____

☐ **Concurrent Review**

Admit Date: _____ **Target Discharge Date:** _____

Additional # of Days being Requested: _____

Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:	Date of Surgery / Onset of Illness:	Type of Surgery:

Level of Function prior to Surgery / Illness:	Use of Assist Device (s) prior to Surgery / Illness:

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

A. Date: _____ **INITIAL Functional Status/Level of Assistance:** **Use minimum, moderate, maximum, contact guard assist, standby assist designation.*

Cognition: _____	UB Dressing: _____	Sitting Balance: _____	Gait: _____
Bed Mobility: _____	LB Dressing: _____	Standing Balance: _____	Gait Assist Device: _____
Activity Tolerance: _____	Feeding: _____	Strength: _____	Gait Distance: _____
Toileting: _____	Diet: _____	Transfers: _____	Stairs: _____
Bathing: _____	Enteral Feeding? ☐ Yes ☐ No	WB Restrictions: _____	# of Steps Patient Can Do: _____

B. Date: _____ **CURRENT Functional Status/Level of Assistance:** ***Use minimum, moderate, maximum, contact guard assist, standby assist designation.*

Cognition: _____	UB Dressing: _____	Sitting Balance: _____	Gait: _____
Bed Mobility: _____	LB Dressing: _____	Standing Balance: _____	Gait Assist Device: _____
Activity Tolerance: _____	Feeding: _____	Strength: _____	Gait Distance: _____
Toileting: _____	Diet: _____	Transfers: _____	Stairs: _____
Bathing: _____	Enteral Feeding? ☐ Yes ☐ No	WB Restrictions: _____	# of Steps Patient Can Do: _____

Skilled Needs / IV Therapy:	Skilled Needs / Wound Care:
Fluids/Medication: _____	Wound Location: _____ Length (cm): _____ Width (cm): _____ Depth (cm): _____
Frequency: _____	Orders: _____ Frequency: _____ Wound VAC (NPWT)? ☐ Yes ☐ No

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.***