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

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

Section II: PROVIDER INFORMATION

Date Requested:		Facility Name:	
Facility NPI #:	Facility Tax ID #:	Facility Address:	
Facility Contact Person:	Case Manager:	Phone: ( )	Facsimile: ( )

Type of Admission: (*Please check*) ☐ Direct Admit from Home ☐ Transfer from Outside Facility (*Name of Facility:* _____)

Section III: CLINICAL INFORMATION

☐ **Initial Request** **Admit Date:** _____ **# of days requested:** _____ **Estimated length of stay:** _____	☐ **Concurrent Review** **Admit Date:** _____ **# of days requested:** _____ **Target Discharge Date:** _____
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 home: _____ Number of steps to enter the home: _____ Number of steps within the home: _____

Bedroom level: _____ Bathroom level: _____ Kitchen level: _____ Does the patient live alone? ☐ Yes ☐ No

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

Date: _____ Cognition: _____ Bed mobility: _____ Activity Tolerance: _____

Transfers: _____ Assist Device: _____ Sit-to-Stand: _____ Sit-to-Supine: _____Supine-to-Sit: _____

Gait: _____ Assist Device: _____ Distance: _____ Stairs: _____ # of steps patient can do: _____

Toileting: _____ Bathing: _____ Continent of Bladder? ☐ Yes ☐ No Continent of Bowel? ☐ Yes ☐ No

UB Dressing: _____ LB Dressing: _____ Feeding: _____ Diet: _____ Enteral Feeding? ☐ Yes ☐ No

Sitting Balance: _____ Standing Balance: _____ Strength: _____ Weight Bearing Restrictions: _____

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

Date: _____ Cognition: _____ Bed mobility: _____ Activity Tolerance: _____

Transfers: _____ Assist Device: _____ Sit-to-Stand: _____ Sit-to-Supine: _____Supine-to-Sit: _____

Gait: _____ Assist Device: _____ Distance: _____ Stairs: _____ # of steps patient can do: _____

Toileting: _____ Bathing: _____ Continent of Bladder? ☐ Yes ☐ No Continent of Bowel? ☐ Yes ☐ No

UB Dressing: _____ LB Dressing: _____ Feeding: _____ Diet: _____ Enteral Feeding? ☐ Yes ☐ No

Sitting Balance: _____ Standing Balance: _____ Strength: _____ Weight Bearing Restrictions: _____

C. Skilled Needs:

IV therapy *(please specify therapy & frequency)*: _____ PICC line? ☐ Yes ☐ No

Wound care orders *(please specify treatment & frequency)*: _____

Wound Location: _____ Length (cm) _____ Width (cm) _____ Depth (cm) _____ Wound VAC (NPWT)? ☐ Yes ☐ No

Other (please specify): _____

Additional Comments:

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