PEHP Health & Benefits

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

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: ( )

Referral Source (*Be specific*): _____ **If referral source was a hospital please submit a copy of the referral (contractual adherence).*

Section III: CLINICAL INFORMATION

☐ **Initial Request** **Admit Date:** _____	☐ **Concurrent Review** **Admit Date:** _____
# of days requested: _____ **Estimated length of stay:** _____	**# 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: Does the patient live alone? ☐ No ☐ Yes

Single or multi-level home: _____ Number of steps to enter the home: _____ Number of steps within the home: _____

A. 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: _____ Transfers: _____ Activity Tolerance: _____ Strength: _____

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

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

B. 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: _____ Transfers: _____ Activity Tolerance: _____ Strength: _____

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

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

Additional Comments:

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