

Skilled Stay Continued Authorization Request

Please fax to: 1-855-773-9287, Attn: Choose an item.

Date: _____
 From Facility: _____ Sender Name: _____
 Member Name: _____ Phone: _____ Fax: _____
 Member ID: _____ Diagnosis: _____
 Date of Admission: _____ Provider Following: Optum Other

Line of Business MCCC ALTCS MCA NOMNC copy attached (ENSURE ACCURATE)

Eating	Bed Mobility	Dressing /UB/LB	Bathing	Transfers	Supine-sit	Sit-Stand	Ambulation/distance (in ft).

Key: I (Independent) SBA (Stand By Assist with supervision) CGA (Contact Guard Assist) Min A (Minimal assist) Mod A (Moderate assistance) Max A (maximum assistance). Include: Therapy minutes/week.

Current skilled needs: O2 PT SP OT IV Abx TPN IVF VENT TRACH

In House HD

Statement of Progress Toward Goals:

Skilled Nursing Details with Start and End dates: (IVF/Abx type, frequency and anticipated end date, TPN, CPM, O2, Vent/trach details)

Wound Care (measurements, treatment, frequency):

Behavioral Health Issues:

RUGS: 5day: _____ 14 day: _____ 30 day: _____ 60 day: _____ 90 day: _____

Requested Length of Stay: _____

ALTCS Status: _____ Date Applied/Review Done: _____ Medical Financial

Discharge Plan: Anticipated D/C date/ELOS: _____

Anticipated disposition: _____

Home/Family support: _____

Barriers to discharge: _____

PRIOR Level of functioning: _____

D/C Needs (HHC/DME/f/u apt. – current and anticipated needing): _____

****LACK OF DISCHARGE INFORMATION MAY RESULT IN A MEDICALLY NECESSARY DENIAL BEING ISSUED.****