MASSACHUSETTS STANDARD FORM FOR INITIAL SNF/REHAB/LTACH PRIOR AUTHORIZATION REQUESTS

USE THIS FORM TO REQUEST AUTHORIZATION (OR INITIAL PRECERTIFICATION) FOR SKILLED NURSING, LONG-TERM CARE HOSPITAL, OR REHABILITATION HOSPITAL SERVICES. DO NOT USE THIS FORM TO REQUEST AUTHORIZATION FOR PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY FOR MEMBERS IN LONG-TERM CARE.

SECTION A. MEMBER INFORMATION	
Member Name:	Date of Birth (mm/dd/yyyy):
ID Number:	Date of Notification (mm/dd/yyyy):
Guardianship or POA:	
Advance Directives:	

SECTION B. FACILITY INFORMATION		
Facility Referred to (Receiving Facility):		
Address:		Facility NPI:
Facility Phone:	Facility Fax:	
Facility Attending MD:		Facility Attending MD NPI:
Facility Attending MD Phone:	Facility Attending MD Fax:	
Facility Attending MD Address:		
Referred from Acute Facility or Home:		
Referring MD (Acute Attending, PCP or Specialist):		
Referring MD Phone:	Acute Attending MD NPI:	
Place of Service Requested: ☐ SNF/TCU ☐ Acute Rehab ☐ LTACH ☐ IRF		
Level of Care Requested (If Applicable):		

SECTION C. ADMISSION INFORMATION	
Facility Anticipated Admit Date:	
Facility Case Manager:	Referring Facility Case Manager:
Facility Case Manager Phone:	Referring Facility Case Manager Phone:
PASRR Completion: ☐ Yes ☐ No	Referring Facility Case Manager Fax:
Admission Contact Name:	Admission Contact Phone:

SECTION D. ADMISSION INFORMATION	
Diagnosis:	Diagnosis Code:
Review of Acute Care Admission:	
Known Medical Problems:	
Social History:	

**Ambulance services reminder. Members requiring ambulance services must be transported by a participating ambulance provider.*

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SECTION E. CURRENT CLINICAL STATUS/TREATMENT *(May Attach Additional Information if Applicable)*	
Mental Status: ☐ AA&O ☐ Confused ☐ Sundowner	
Pain _____/10	Pain Location *(specify)*:
Able to Participate in Treatment: ☐ Yes ☐ No If no, *(specify)*:	
O_2 Dependent: ☐ Yes ☐ No If yes, *(specify O_2 liters)*:	
Trach: ☐ Yes ☐ No If yes, *(specify)*:	
Vent: ☐ Yes ☐ No If yes, *(specify settings and weaning plan)*:	
Suctioning: ☐ Yes ☐ No If yes, *(specify needed frequency)*:	
Wound Management: ☐ Yes ☐ No If yes, *(specify location[s], stage, treatment)*:	
Tube Feeding (Enteral Feeds): ☐ Yes ☐ No If yes, *(specify)*:	
TPN/PPN: ☐ Yes ☐ No If yes, *(specify)*:	
IV Therapy: ☐ Yes ☐ No If yes, *(specify name, frequency, duration)*:	
Lab Monitoring: ☐ Yes ☐ No If yes, *(specify)*:	
Dialysis: ☐ Yes ☐ No If yes, *(specify)*:	
Mobility Assistance: ☐ Independent ☐ Supervision ☐ Contact Guard ☐ Min Asst ☐ Max Asst ☐ Total Asst	
ADL: ☐ Independent ☐ Supervision ☐ Contact Guard ☐ Min Asst ☐ Max Asst ☐ Total Asst	
Speech Therapy Needs: Speech: ☐ Yes ☐ No If yes, *(specify)*: _____ Swallowing: ☐ Yes ☐ No If yes, *(specify)*: _____ Cognition: ☐ Yes ☐ No If yes, *(specify)*: _____	
Mobility Distance: ☐ N/A ☐ *(Specify feet)*:	
Mobility Endurance: ☐ N/A ☐ Distance *(Specify feet)*:	
Mobility with Device: ☐ Yes ☐ No ☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other *(specify)*: _____	
Post Acute PT Required: ☐ Yes ☐ No If yes, *(specify)*:	
Post Acute OT Required: ☐ Yes ☐ No If yes, *(specify)*:	
Post Acute ST Required: ☐ Yes ☐ No If yes, *(specify)*:	
Other, *please specify*:	

SECTION F. PRIOR LEVEL OF FUNCTION/TREATMENT							
	Independent	**Supervision**	**Contact Guard**	**Min Asst**	**Mod Asst**	**Max Asst**	**Independent**
ADL							
Bed Mobility							
Transfers							
Ambulation							

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SECTION G. PRIOR HOME ENVIRONMENT

Place of Residence Prior to Admission *(Free Form Answer Box)*:

Prior Environment Status: ☐ Lives Alone ☐ Lives with Significant Other/Spouse ☐ Lives with Others ☐ Homeless

Other, *please specify*: _____

Number of Levels at Home: _____	Elevator Access? ☐ Yes ☐ No
Number of Stairs to Enter Home: _____	Ramp Access? ☐ Yes ☐ No Rails? ☐ Yes ☐ No
Number of Interior Stairs: _____	Ramp Access? ☐ Yes ☐ No Rails? ☐ Yes ☐ No

Bathroom Location: ☐ 1st Floor ☐ 2nd Floor ☐ 3rd Floor ☐ Other, *please specify:*

Bedroom Location: ☐ 1st Floor ☐ 2nd Floor ☐ 3rd Floor ☐ Other, *please specify:*

Support Hours/Day Available:

Provided by (Informal Support):

Paid Formal Support (Name of Organization):

Current Home Equipment:

Community Supports: ☐ Transportation ☐ Shopping ☐ Laundry ☐ Meals

SECTION H. DISCHARGE PLAN/GOALS

Discharge Plan:

Eventual Discharge Date:

Caregiver: ☐ Yes ☐ No

Caregiver Contact Information:

Social Barriers/Psychosocial Issues:

Potential Barriers to Discharge: