Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Inpatient Rehabilitation

Fax this request to: (866) 480-9903 For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

REQUEST TYPE: ☒ Admission ☐ Continued Stay ☐ Retrospective ☐ Unscheduled Revision

REQUIRED FOR RETROSPECTIVE REVIEWS ONLY
This recipient was determined eligible for Medicaid benefits on: _____ /_____ /_____

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:		DOB:
Address:	Phone:	
City:	State:	Zip Code:
Guardian Name (if applicable):		Guardian Phone:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name:		

SERVICING / RECEIVING PROVIDER INFORMATION

Rehabilitation Facility Name:		
NPI:		
Facility Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name:		

CLINICAL INFORMATION

Is this request for Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No

Check the box next to each deficit that applies: ☐ ADLs ☐ Ambulation ☐ Bowel ☐ Bladder ☐ Communication ☐ Cognitive ☐ Mobility ☐ Weight Bearing Restrictions

Ventilator: ☐ Yes ☐ No	Is a pressure ulcer present? ☐ No ☐ Yes: Location: _____
FIMS: _____	Stage: _____ Measurements: _____

Rancho Los Amigos Scale *(for head injury)*:	Feeding Status:

Estimated Admittance Date: _____ Estimated Length of Stay: _____ days

Estimated Discharge Date: _____

Rehabilitation Diagnosis Code	Description
1.	
2.	
3.	

Inpatient Rehabilitation

Other Diagnosis Code	Description
1.	
2.	
3.	

Functional Deficits and Prognosis for Improvement: _____

_____

_____

_____

Treatment Plan and Goals: _____

_____

_____

_____

_____

_____

Discharge Plan, Destination and Available Support: _____

_____

_____

_____

_____

_____

NEVADA MEDICAID USE ONLY

☐ Recipient is tentatively accepted as a candidate for a rehabilitation program.
☐ Recipient is a potential candidate for a rehabilitation program, but cannot be admitted at this time due to:
- ☐ Insurance Authorization ☐ Discharge Plan Currently Unavailable
- ☐ Medical Contraindications ☐ Unable to Actively Participate in the Rehabilitation Program
- ☐ Awaiting Consults From: ☐ PT ☐ OT ☐ CT ☐ RT ☐ Social Work

☐ Recipient is not accepted into the rehabilitation program at this time for the following reason(s):

Approved Procedures:	
Appoved From:	Approved Through:
Denied Procedures:	
Denied From:	Denied Through:
Reviewer Signature:	Date: