

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:

Approved From:	Approved Through:
----------------	-------------------

Denied Procedures:

Denied From:	Denied Through:
--------------	-----------------

Reviewer Signature:	Date:
---------------------	-------

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.