Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Long Term Acute Care

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 Review* ☐ 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:		
City:	State:	Zip Code:
Phone:		
Medicare Coverage: ☐ Part A ☐ Part B	ID Number:	
Other Insurance Name:	ID Number:	

ORDERING PROVIDER INFORMATION

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

TREATMENT FACILITY INFORMATION

Facility Name:	NPI:		
Facility Address:	City:	State:	Zip Code:
Phone:	Fax:		
Estimated Admit Date:	Estimated Length of Stay:		
Estimated Number of Necessary Treatments:			
Room and Board Revenue Codes:			

CLINICAL INFORMATION

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

Diagnosis *(include ICD-9 codes if available)*:

Reason(s) for admission:

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PREREQUISITES/SEVERITY OF ILLNESS

The recipient must meet both of the following conditions. Check all boxes that apply.

☐ Potential or actual instability of medical conditions (e.g., diabetes, renal disease, cardiovascular disease, respiratory insufficiency) that requires frequent, ongoing management and treatment. Unstable medical conditions are those deficits that are unchanged or improving and can lead to severe morbidity if not promptly treated.

☐ Ability to perform basic Activities of Daily Living (ADL) is restricted due to unresolved, complex medical problems.

The recipient must meet the requirements for one or more of the following treatment categories (Complex Medical Treatment, IV and Respiratory Therapy and/or Other Treatment). Check all boxes that apply.

COMPLEX MEDICAL TREATMENT - *To meet the requirements of this treatment category, at least one of the following items must apply to the recipient. Check all boxes that apply.*

☐ One-to-one care	☐ Tracheostomy weaning
☐ Isolation, respiratory/strict	☐ Ventilator care and/or weaning
☐ Day surgery recovery: first 48 hours. This applies only when the recipient was a resident of the long-term acute care facility prior to surgery.	☐ Wound care, complex: debridement, packing, KCL vacuum suction, hyperbaric chamber, prosthetic management, stump care
☐ Medication drip, continuous	

IV AND RESPIRATORY THERAPY - *To meet the requirements of this treatment category, at least two of the following items must apply to the recipient. Check all boxes that apply.*

☐ Blood transfusion	☐ IV antibiotics
☐ Central line maintenance	☐ TPN
☐ Chemotherapy	☐ Hydration: does not include tube feedings or TKO
☐ Respiratory care, intermittent or continuous, at least every 8 hours	☐ IV medications/steroids: does not include tube feedings or TKO

OTHER TREATMENT - *To meet the requirements of this treatment category, at least three of the following items must apply to the recipient. Check all boxes that apply.*

☐ Feedings, tube	☐ Progressive activity program: PT, OT, speech
☐ GI suction and drainage	☐ Sequential pneumatic stockings
☐ Hemodialysis, onsite	☐ Suctioning
☐ Irrigations (sterile, cath, NG, GT)	☐ Training, bowel and bladder
☐ Nutritional counseling	☐ Wound care, basic
☐ Neuro checks	☐ Vital sign monitoring at least every 2 hours
☐ Medications, intramuscular or subcutaneous, at least every 8 hours	☐ Labs, frequent monitoring and intervention: includes accu checks and insulin adjustment
☐ Ostomy management (e.g., trache, colostomy)	

NEVADA MEDICAID USE ONLY

Approved From:	Approved To:	
Denied From:	Denied To:	
Reviewer Signature:		Date: