LTAC precertification form

This form is intended to help facilitate precertification for admission to a long-term acute care (LTAC) facility. Please complete this form and fax it, along with the items below, to
215-238-2538 – Attention: LTAC PRECERTIFICATION

Fax the following information along with your completed form:

- a physician-written order for LTAC transfer
- the last five days of physician progress notes
- a complete list of all current medications including IV antibiotic end date(s)
- the most recent test results and related consults (CT scan, X-rays, ultrasound, etc.)

- **Ventilator Weaning Requests** – ventilator flow sheets with the last four days of weaning trials

You may call **1-866-319-6954** to confirm receipt of your fax.

PATIENT INFORMATION

Patient name:____

Patient ID number:____

Reviewer's name and contact number:_________________________

Date of hospital admission:___________________________________

Current location:____

Admitting Dx and ICD-10 code for this admission:_______________

COVID-19 positive or negative? Date of latest COVID-19 test:____________

____

Is patient medically stable for discharge in next 24 hours? Yes / No

____

PMHx: ______________________

PTA prior level of function/home arrangements: ______________________

Anticipated D/C plan/Caregiver availability/Able-bodied caregiver: ______________________

____

Responsible party and phone number: ______________________

DME items in home/DME needs: ______________________

Attending physician/Phone number/NPI number:______________________

____

Accepting LTAC facility/Address/Phone number:______________________

____

Accepting LTAC physician/Phone number/NPI number:______________________

____

If requested facility is out-of-network (OON)…

Has the member used this OON provider before? ________________________________

Member's rationale for choosing this OON provider: ________________________

Is this OON provider the only provider who can perform the service? ________________

In-network providers attempted: ___________________________________

Facility fax number: ___________________________________

MEDICALLY COMPLEX ISSUES

Current needs/Active medical issues: ___________________________________

Nutritional intake/Feeding product/Volume/Frequency per day: ____________________________

Method of delivery: ___________________________________

Tube feeding type: N/A   Date inserted: ___________________________________

Pain/Site: ___________________________________

Pain treatment: ___________________________________

Lab values: ___________________________________

RESPIRATORY

O_2/Ventilator/Trach settings: N/A

Trach (size/type): ___________________________________

PMV (yes/no, usage frequency): ___________________________________

Suctioning (frequency/description): ___________________________________

O_2/Saturation reading (%): __________________

Neb Tx: ___________________________________

CXR: ___________________________________

Decannulation: ___________________________________

WOUND/SKIN

Skin intact: Yes / No

Wound location: ___________________________________

Size: ___________________________________

Stage: ___________________________________

Drainage (amount and type): ___________________________________

Treatment: ___________________________________
Recent debridement/Date: ___________________________________
Most recent wound care notes: ___________________________________
____
____
____
____
____
____
____

ADDITIONAL INFORMATION

NEURO: AAOX ___________________________________
Glascow Coma Scales: ___________________________________
Comments: ____
____
____
____
____
____
____
____

Placement issues (if applicable): List the name of any **SKILLED** and/or **SUBACUTE** facilities that have ***denied*** the patient for admission and their ***reason for denial.***

1. ____
2. ____
3. ____
4. ____
5. ____

Post-LTAC placement issues (if applicable): ____
____
____
____
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