Skilled Stay Continued Authorization Request

Please fax to: 1-855-773-9287, Attn: Choose an item.

Date: _____

From Facility: _____ **Sender Name:** _____

Member Name: _____ **Phone:** _____ **Fax:** _____

Member ID: _____ **Diagnosis:** _____

Date of Admission: _____ **Provider Following: Optum** ☐ **Other** ☐

Line of Business ☐ MCCC ☐ ALTCS ☐ MCA ☐ NOMNC copy attached **(ENSURE ACCURATE)**

Eating	Bed Mobility	Dressing /UB/LB	Bathing	Transfers	Supine-sit	Sit-Stand	Ambulation/distance (in ft).
Key:	I (Independent) SBA (Stand By Assist with supervision) CGA (Contact Guard Assist) Min A (Minimal assist) Mod A (Moderate assistance) Max A (maximum assistance). Include: Therapy minutes/week.						

Current skilled needs: ☐ **O2** ☐ **PT** ☐ **SP** ☐ **OT** ☐ **IV Abx** ☐ **TPN** ☐ **IVF** ☐ **VENT** ☐ **TRACH** ☐ **In House HD**

Statement of Progress Toward Goals:
Skilled Nursing Details with Start and End dates: (IVF/Abx type, frequency and anticipated end date, TPN, CPM, 02, Vent/trach details)
Wound Care (measurements, treatment, frequency):
Behavioral Health Issues:

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RUGS: 5day: _____ **14 day:** _____ **30 day:** _____ **60 day:** _____ **90 day:** _____

Requested Length of Stay:_____

ALTCS Status: _____ ***Date Applied/Review Done*:**_____ ***Medical*** ☐ ***Financial*** ☐

Discharge Plan: Anticipated D/C date/ELOS:

Anticipated disposition:

Home/Family support:

Barriers to discharge:

PRIOR Level of functioning:

D/C Needs (HHC/DME/f/u apt. – current and anticipated needing):

****LACK OF DISCHARGE INFORMATION MAY RESULT IN A MEDICALLY NECESSARY DENIAL BEING ISSUED.****

Updated 07/01/18