Independence

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): _____