

Authorization request for SNF, Acute Rehab and LTAC



Email: UUHPtransition@hsc.utah.edu

(Please send email encrypted to protect PHI)

Phone: 801-587-6480 Option #2

Fax: 801-281-6121

Date of Request: _____

No. pages included in this request: _____

<https://uhealthplan.utah.edu/forproviders/box-um.php>

**Please submit completed request by 3:00 pm
to allow enough time for review**

Patient Name: _____ DOB: ____/____/____ ID # _____

Requesting Facility: _____

Admissions Contact: _____ Phone: _____

Concurrent Review Contact: _____ Phone: _____

Address: _____ Fax: _____

Admission Date to facility: _____ Anticipated Discharge Date: _____

Please submit page 1 on initial request and Page 2 for concurrent review.

Check all skilled services that apply:		
IV Medication:	Frequency of Medication:	Start date & End date:
Respiratory status:	Oxygen: Yes No	Tracheotomy: Yes No
Ventilator: Yes No	Wean Trials:	Ventilator settings:
Skilled Wound Care: _____ Site/ measurement/description: _____ Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Not staged Treatment frequency: <input type="checkbox"/> QD <input type="checkbox"/> BID <input type="checkbox"/> TID Dressing Type: _____ Wound Vac: _____ Note: If multiple wounds, please attach wound assessment sheets.		

Initial approval is valid for the first 3 days of admission as indicated above. Please submit therapies evaluations/treatment plans for medical review within 72 hours of admission. For ongoing stay authorization beyond initial 3 days, please submit page 2 with ongoing therapies notes and minutes for review on a weekly basis. Please notify us *immediately* if member leaves against medical advice (AMA)

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Patient's Name: _____ Date: _____

CONCURRENT REVIEW-Please check Applicable Level of Assistance Needed (Attach documents to support your Assessment).

Date of Functional Level Assessment:

	Independent	Modified Independence	Supervision/ Stand by Assist	Contact Guard/ Minimal assist	Moderate Assistance	Maximum Assistance	Total Assistance
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PT Minutes:

Bed Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stairs/ Number	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OT Minutes:

Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UB Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LB Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ST Minutes:

Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ambulation (distance in feet): _____

Weight Bearing status (Device): _____

Wheelchair mobility Distance: _____

Notes: