LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

STATE OF CALIFORNIA DEPARTMENT HEALTH SERVICES

PLEASE TYPE ALL REQUIRED INFORMATION

1 FOR FI USE ONLY

CCN

CONFIDENTIAL PATIENT INFORMATION

Elite Pica

Typewriter Alignment

Elite Pica

SERVICE CATEGORY

CHECK ONLY ONE BOX

TRANSFER | INITIAL | REAUTHO IZATION | SKILLED NURSING CARE | INTERMEDIATE CARE | I.C.F. D.D. | SPECIAL PROGRAM FORM LIC 231 ATTACHED

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES NO

PROVIDER PHONE NO. ( ) AREA

PROVIDER NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

2 PROVIDER NUMBER

FI USE ONLY 3 4 5 6

MEDICAL RECORD NUMBER

6 PATIENT NAME (LAST, FIRST, M.I.)

7 MEDI-CAL IDENTIFICATION NO.

8 PEND.

9 ADMIT DATE. THIS SERVICE

10 MEDICARE STATUS

11 DATE BENEFITS EXHAUSTED

12 SEX

13 DATE OF BIRTH

14 ADMIT FROM

15 SOCIAL SECURITY CLAIM NO.

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED (FROM) DATE (T0) DATE

16 PRIM. DX CODE

CURRENT DIAGNOSES

A. (PRIMARY):

(SECONDARY)

NAME OF FORMER FACILITY

FACILITY

B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY

C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

☑ BEDRIDDEN ☑ TOTALLY INCONTINENT ☑ SPOONFED ☑ CONFINED TO WHEELCHAIR ☑ AMBULATORY W. ASSISTANCE ☐ AMBULATORY

SPECIFY

D. DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE):

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PHYSICIAN NAME & PHONE NO.

17 PHYSICIAN MEDI-CAL IDENTIFICATION NO.

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN DATE

PART III FOR STATE USE

18 PROVIDER; YOUR REQUEST IS:

1 ☐ APPROVED AS REQUESTED

2 ☐ APPROVED AS MODIFIED SEE COMMENTS BELOW

3 ☐ DENIED REASON AND ALTER-NATE TREATMENT PLAN RECOMMENDED BELOW

4 ☐ DEFERRED

5 ☐ JACKSON VS RANK PARAGRAPH CODE

BY: (MEDI-CAL CONSULTANT)

X

I D NO 19 DATE 20

REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

21 APPROVED CARE: SNF ☐ ICF ☐ ICF DD ☐

22 SPECIAL PROGRAM: M D SOB ☐ M D REHAB ☐ NO SPECIAL PROGRAM ☐

FOCUS REVIEW

23 FROM (DATE) (Y/N)

24 THRU (DATE) (Y/N)

CHART REVIEWED

PROLONGED CARE YES ☐ NO ☐

ADMIN. DAYS (BED NOT AVAILABLE)

PENDING (REQUEST FOR FAIR HEARING)

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

TAR CONTROL NUMBER

OFFICE SEQUENCE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

20-IZ 12/87