Long-Term Care Authorization Notification Form

Directions: Complete this form to request inpatient long-term care-related services. Attach the Minimum Data Set (MDS), Pre-Admission Screening and Resident Review (PASRR), Treatment Authorization Request (TAR), and any Medi-Cal non-coverage notification to support medical necessity for services. Fax the completed form to the Community Health Plan of Imperial Valley "CHPIV" Long-Term Care (LTC) Intake Line at **855-851-4563**. To check the status of your request, call the LTC Intake Line at **800-453-3033**.

Today's date: _____

Member name: _____ Date of birth: _____ Member #: _____

Designate type of request by checking appropriate boxes below: **Original admission date:** _____

Last admission date: _____

- ☐ Routine request (elective)
- ☐ Urgent request (if care is not received urgently, the member's life/health or ability to regain maximum function could be seriously jeopardized). Select one:
- ☐ New authorization request for new admission ☐ Reauthorization request

Designate service(s) requested by checking appropriate box below: **Date of requested services**: _____

Inpatient Admission

Is patient re-admitted from an acute hospital back to your facility from a bed hold? ◯ Yes ◯ No

If yes, include existing CHPIV long-term care authorization number: _____ Date of re-admission: _____

- ☐ Subacute
- ☐ Nursing facility level A
- ☐ Nursing facility level B
- ☐ Long-term custodial services
- ☐ Short-term skilled nursing services

Long-term care services that are not included in per diem or covered by any other insurance.

- ☐ Physical, speech or occupation therapy services
- ☐ Durable medical equipment (DME)
- ☐ Other: _____

Requesting/ordering provider information			**Servicing provider where member will receive services**		
First and last name of requesting provider:		Tax ID/NPI:	Name of hospital/facility or provider of services/product (no abbreviations):		
Address			Tax ID # of above:	NPI of above:	
City/State/ZIP Code			Address		
Area code	Phone # + ext.	Fax #	City/State/ZIP Code		
Requesting/ordering contact name (**required**):		Phone # + ext.	Area code	Phone # + ext.	Fax #

Clinical Information			
ICD-10 code(s) (**required**):	Diagnosis description:		Date of onset/injury:
CPT code(s) (**required**):	# of visits	Describe service requested (Note: Billed CPT codes not approved may require clinical review upon submission of claim and report):	

Providers must submit the MDS, PASRR, TAR, and any notice of Medi-Cal non-coverage notification with the authorization notification as applicable.

Hospice services are not a benefit of long-term care. To request authorization for hospice services, a separate Outpatient (OP) Authorization is required and must include the hospice agency and the facility that the member is residing in at time of services.

Physician or case manager signature: _____ Contact number: _____