Highmark Blue Shield
LONG-TERM ACUTE CARE FACILITY PRECERTIFICATION FORM

Submission Instructions: Please print all information.

IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS.** Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.

Please fax completed form to the Medical Management and Policy Department: **800.416.9195** *(Initial Pennsylvania Requests)* **877.650.6019** *(Initial Delaware Requests)* **888.676.6795** *(Extensions of Regional LTAC)*

Type of Request:

PICK ONE: **INITIAL REQUEST** ☐ **EXTENSION REQUEST** ☐

Member Information

Member Name:		DOB:	Age:
Member UMI:	Member Phone #	Planned DOS:	
Workers' Comp: ☐ Yes ☐ No			

LTAC Facility Information

Facility Name:		NPI:	
Address:			
City:		State:	ZIP:
Phone Number:		Fax Number:	
Contact Person:		Phone Number:	

Physician Information

Admitting Physician's Name:		NPI:	
Address:			
City:		State:	ZIP:
Phone Number:		Fax Number:	
Contact Person:		Phone Number:	

Transferring Facility Information

Facility Name:			
Address:			
City:		State:	ZIP:
Phone Number:		Fax Number:	
Contact Person:		Phone Number:	
Admitting Diagnosis:		Secondary Diagnosis:	

Transition of Care/Discharge Plan:	
Target Discharge Date:	
Discharge Medications:	
Home with MD Follow Up:	Home Health Services (specify):
SNF:	RHB:
DME Needs:	Other:

Member Name:	**Member ID:**

Comorbidities:

Recent Surgeries:

Current Problems:

Past Medical History:

Vital Signs:	Date:	Temp:	BP:	RR:	HR:

Cardiac Monitoring: ☐ Yes ☐ No

Respiratory Status: Breath Sounds:

Oxygen: Mask/Nasal Cannula/Trach Collar @ ________________ Liters	Suctioning:	Vent: ☐ Yes ☐ No

Vent Settings:	Rate:	FiO_2:	TV:	PSV:	BiPAP:	CPAP:	PEEP:
Weaning Attempts:	☐ Failed Date:		☐ HR ☐ CHF ☐ RR ☐ Desat			Other:	
ABGs/Date:	FiO_2:	PH:	PaO_2:	$PaCO_2$:	O2 Sats:	HCO3:	BE:

Dialysis: ☐ Yes ☐ No	Type:	Frequency:
Nutrition:	Height:	Weight:

Feedings:

Type:

Parenteral Nutrition: ☐ TPN ☐ PPN	Other:

Cultures: ☐ Sputum ☐ Blood ☐ Urine ☐ Wound ☐ Stool	Isolation: ☐ Yes ☐ No

Skin: Describe any wounds, drains, etc.

Site:	Stage/Size:	Treatment:
Comments:		
Site:	Stage/Size:	Treatment:
Comments:		
Site:	Stage/Size:	Treatment:
Comments:		

Blood Products: ☐ Yes ☐ No Type:

Neurological: ☐ Alert ☐ Oriented ☐ Forgetful ☐ Confused ☐ Lethargic ☐ Non-Responsive ☐ Comatose ☐ Sedated

Radiology/Laboratory—Please include any recent results:

Musculoskeletal: ADLs: ☐ Independent ☐ Assist ☐ Total	Transfers: ☐ Ind. ☐ Min. ☐ Mod. ☐ Max.

Weight Bearing: ☐ Non-WB ☐ Partial WB ☐ Full WB

Member Name	**Member ID**
Prior Level of Functioning:	

Therapies:

☐ Physical ☐ Occupational ☐ Speech Frequency: ___________________________

Comments:

Therapy Goals:

Medications:

Treatments/Plan of Care

Prior Functional Status:

Primary Caretaker:

Prior Living Arrangements:	☐ House ☐ Apartment Other:	☐ Alone ☐ Spouse ☐ Children Other:

Comments:

Complete following section ONLY if request is for EXTENSION of services:

Specific reasons for continued service, progress, or any other pertinent info related to extension of services:

INTERNAL USE ONLY:

Decision: ☐ Approved ☐ Denied	Medical Director:	Nurse Reviewer:
Reconsideration: ☐ Upheld ☐ Overturned	Medical Director:	Nurse Reviewer: