

Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Long Term Acute Care

Upload this request through the Provider Web Portal.

For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: ____ / ____ / ____

REQUEST TYPE: Admission Continued Stay Retrospective Review* Unscheduled Revision

*REQUIRED FOR RETROSPECTIVE REVIEWS ONLY

This recipient was determined eligible for Medicaid benefits on: ____ / ____ / ____

NOTES:

RECIPIENT INFORMATION

Recipient Name:

Recipient ID:

DOB:

Address:

City:

State:

Zip Code:

Phone:

Medicare Coverage: Part A Part B ID Number:

Other Insurance Name:

ID Number:

ORDERING PROVIDER INFORMATION

Provider Name:

NPI:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

TREATMENT FACILITY INFORMATION

Facility Name:

NPI:

Facility Address:

City:

State:

Zip Code:

Phone:

Fax:

Estimated Admit Date:

Estimated Length of Stay:

Estimated Number of Necessary Treatments:

Room and Board Revenue Codes:

CLINICAL INFORMATION

Is this request for Healthy Kids (EPSDT) referral/services? Yes No

Diagnosis (include ICD-10 codes if available):

Long Term Acute Care

Reason(s) for admission:

PREREQUISITES/SEVERITY OF ILLNESS

The recipient must meet both of the following conditions. Check all boxes that apply.

- Potential or actual instability of medical conditions (e.g., diabetes, renal disease, cardiovascular disease, respiratory insufficiency) that requires frequent, ongoing management and treatment. Unstable medical conditions are those deficits that are unchanged or improving and can lead to severe morbidity if not promptly treated.
- Ability to perform basic Activities of Daily Living (ADL) is restricted due to unresolved, complex medical problems.

The recipient must meet the requirements for one or more of the following treatment categories (Complex Medical Treatment, IV and Respiratory Therapy and/or Other Treatment). Check all boxes that apply.

COMPLEX MEDICAL TREATMENT - *To meet the requirements of this treatment category, at least one of the following items must apply to the recipient. Check all boxes that apply.*

- | | |
|---|---|
| <input type="checkbox"/> One-to-one care | <input type="checkbox"/> Tracheostomy weaning |
| <input type="checkbox"/> Isolation, respiratory/strict | <input type="checkbox"/> Ventilator care and/or weaning |
| <input type="checkbox"/> Day surgery recovery: first 48 hours. This applies only when the recipient was a resident of the long-term acute care facility prior to surgery. | <input type="checkbox"/> Wound care, complex: debridement, packing, KCL vacuum suction, hyperbaric chamber, prosthetic management, stump care |
| <input type="checkbox"/> Medication drip, continuous | |

IV AND RESPIRATORY THERAPY - *To meet the requirements of this treatment category, at least two of the following items must apply to the recipient. Check all boxes that apply.*

- | | |
|---|---|
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> IV antibiotics |
| <input type="checkbox"/> Central line maintenance | <input type="checkbox"/> TPN |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hydration: does not include tube feedings or TKO |
| <input type="checkbox"/> Respiratory care, intermittent or continuous, at least every 8 hours | <input type="checkbox"/> IV medications/steroids: does not include tube feedings or TKO |

OTHER TREATMENT - *To meet the requirements of this treatment category, at least three of the following items must apply to the recipient. Check all boxes that apply.*

- | | |
|---|--|
| <input type="checkbox"/> Feedings, tube | <input type="checkbox"/> Progressive activity program: PT, OT, speech |
| <input type="checkbox"/> GI suction and drainage | <input type="checkbox"/> Sequential pneumatic stockings |
| <input type="checkbox"/> Hemodialysis, onsite | <input type="checkbox"/> Suctioning |
| <input type="checkbox"/> Irrigations (sterile, cath, NG, GT) | <input type="checkbox"/> Training, bowel and bladder |
| <input type="checkbox"/> Nutritional counseling | <input type="checkbox"/> Wound care, basic |
| <input type="checkbox"/> Neuro checks | <input type="checkbox"/> Vital sign monitoring at least every 2 hours |
| <input type="checkbox"/> Medications, intramuscular or subcutaneous, at least every 8 hours | <input type="checkbox"/> Labs, frequent monitoring and intervention: includes accu checks and insulin adjustment |
| <input type="checkbox"/> Ostomy management (e.g., trache, colostomy) | |

This request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.