Long-Term Acute Care (LTAC) Facility Admissions Prior Authorization Request Form

BlueCross BlueShield Minnesota

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity Essentials® Provider Portal to submit pre-service prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross.** Please complete the clinical sections on this form and attach it to your request at Availity.com/essentials to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request. See page 4 for fax instructions.

Type of admission: ☐ Initial ☐ Concurrent – initial authorization number_____

☐ **Request for Urgent Review:** By checking this box, I certify that applying the standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function per federal definition of "Urgent."

Contact Information

Person completing form: _____Phone: _____ Fax:_____

☐ Admitting facility ☐ Ordering facility

Ordering Facility Information

Facility NPI / Tax number: _____ Facility provider ID number: _____

Ordering provider name: _____ Ordering facility name: _____

Ordering facility address: _____

City/state/ZIP: _____

Patient Information

Member name: _____ Gender: ☐ M ☐ F ☐ X

Member ID number: _____ Date of birth: _____

Member address: _____

City/state/ZIP: _____ Phone: _____

Admission Information

Admission date: _____ Estimated length of stay: _____

Facility NPI/Tax number: _____ Facility provider ID number: _____

Admitting facility name: _____

Admitting facility address: _____

Admitting facility city/state/ZIP: _____

Phone: _____ Fax: _____

Admitting diagnosis code: _____ Secondary diagnosis code: _____

Your medical record number (optional): _____

History and Physical

Comorbid/past medical history:

History and Physical (continued)

Most recent vital signs: _____

Most recent Hgb: _____ Hct: _____ Albumin: ____

Recent abnormal lab results? ☐ Yes ☐ No If Yes, please provide details:

Treatment Plan

Trach placed in last 30 days? ☐ Yes ☐ No If Yes, plan to decannulate? ☐ Yes ☐ No

Vent weaning? ☐ Yes ☐ No If Yes, prior weaning attempts? ☐ Yes ☐ No

Current PEEP: _____ FiO2: _____

Respiratory Complex? ☐ Yes ☐ No BiPAP or High Flow settings: _____

Most recent CXR date: _____ Results:_____

Wound care? ☐ Yes ☐ No

Treatment orders and frequency: _____

Wound location(s) and measurement(s): _____

Description of wound(s): _____

Stage of healing: _____

Drainage: _____

Other information: _____

GT/GJ/NG/NJ feedings? ☐ Yes ☐ No If Yes, formula type : _____

Rate and frequency: _____

Medically Complex

Dialysis? ☐ Yes ☐ No If Yes, frequency: _____

Physical therapy? ☐ Yes ☐ No If Yes, current level of function: _____

Occupational therapy? ☐ Yes ☐ No If Yes, current level of function: _____

Speech therapy? ☐ Yes ☐ No If Yes, current level of function: _____

Frequent lab monitoring? ☐ Yes ☐ No If Yes, please provide details: _____

IV/SQ meds? ☐ Yes ☐ No If Yes, please provide details: _____

Is the patient on a continuous paralytic agent? ☐ Yes ☐ No

Discharge Planning

Discharge plan:

Barriers to discharge plan:

Additional notes:

Projected discharge date: _____

Inpatient Admission Guidelines

Providers are required to notify Blue Cross of all inpatient admissions. Some admissions require prior authorization to determine coverage and some admissions require notification only. All admissions must be medically necessary.

Please ensure the request is submitted as soon as the admission is scheduled. If the admission is unplanned, the request must be submitted no later than two working days after the admission occurs.

Once the member has been discharged, please notify us of the discharge date. Discharge information can be added on the Availity® Provider Portal or sent to the fax number listed below.

Documentation Requirements

In addition to filling out the previous pages of this form, please include documentation supporting the medical necessity of this request. Documentation should include:

- History and physical discharge summary (if available)
- Clinical progress notes (for concurrent requests)
- Medication list
- Therapy notes, including level of participation (evaluation and last progress notes)

Concurrent Review

Definition: An ongoing review during the member's stay, to ensure that the continued stay meets established medical necessity criteria. Facility providers are required to submit a concurrent review request when additional days are needed.

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Providers outside of Minnesota without electronic access can call the number below or fax this form, along with clinical records to support the request, to the fax number listed below.

Contact Information

Phone: 1-800-528-0934
Fax: (651) 662-7006