of Tennessee

Commercial Long Term Acute Care Hospitalization (LTACH) Services Authorization Request

LTACH Initial Request: _____ Concurrent Review: _____

Member Information

Member Name: _____ Date of Birth: ____ / ____ / ____

Member ID Number (please included prefix):

_____

Member Phone Number: _____

Have you received a reference number for this case? ☐ No ☐ Yes (include number):

_____

LTACH Facility Information

Expected Admission Date: ____ / ____ / ____

Diagnosis with diagnosis code(s): _____

Facility Name: _____

Contact Name: _____ Phone: _____ Fax: _____

Is the LTACH in one of our networks or a local BlueCross plan? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ NPI Number: _____

Facility Member is transferring from: _____

Transported by: ☐ Air ☐ Ground ☐ Private Vehicle

Admitting Physician Information

Facility Physician Name: _____

Is the Facility Physician in one of our networks or a local BlueCross plan? ☐ Yes ☐ No

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ NPI Number: _____

Clinical Information

Please include the following clinical information:

Reason for LTACH admission (telemetry, ventilator care/weaning, long-term IV antibiotics, complex wound management, frequent lab monitoring, dialysis, daily physician care coordination, etc.)

Recent Hospital History Summary:

Medical/Surgical History:

Comorbidities:

Vitals (heart rate, respiratory rate, blood pressure, oxygen saturation):

Neuro (level of orientation, behavior):

Cardiac (telemetry, cardiac issues, treatment plan):

Respiratory (current ventilator settings when intubated, trach clinical, weaning attempts, plan of care, O2 saturations):

GI (diet, route, PEG/NG, TPN):

Genitourinary (foley, dialysis):

Musculoskeletal (therapies, current functional level, braces, restrictions, prior level of function):

Infection Control (isolation, positive cultures):

Pain Management:

IV Medications (antibiotics with anticipated end date, cardiac IV meds):

Recent Lab Values:

Skin/Wounds (description of wounds, wound care orders, durable medical equipment):

Psychosocial (living arrangement, home access, caregiver):

Discharge Planning (estimated length of stay, anticipated discharge destination/plan):

Please complete this form and submit it as an attachment through one of the following options.
Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call **(423) 535-5717**, **option 2**, or contact your eBusiness Network Manager.

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