



LONG TERM CARE TREATMENT AUTHORIZATION REQUEST

**CONFIDENTIAL
PATIENT
INFORMATION**

STATE OF CALIFORNIA
DEPARTMENT
HEALTH SERVICES
PLEASE TYPE ALL
REQUIRED
INFORMATION

1 FOR FI USE ONLY

CCN

SERVICE CATEGORY: Elite Pica

Typewriter Alignment

TRANSFER INITIAL REAUTHORIZATION

SKILLED NURSING CARE INTERMEDIATE CARE I.C.F. D.D. SPECIAL PROGRAM FORM LIC 231 ATTACHED

PART I FOR PROVIDER USE

VERBAL CONTROL NO.

REQUEST IS RETROACTIVE? YES NO

PROVIDER PHONE NO. AREA

PROVIDER NAME AND ADDRESS

2 PROVIDER NUMBER

FI USE ONLY

3 4 5 6

MEDICAL RECORD NUMBER

PATIENT NAME (LAST, FIRST, M.I.)

MEDI-CAL IDENTIFICATION NO. PEND.

ADMIT DATE MEDICARE DATE SEX DATE OF BIRTH ADMIT SOCIAL SECURITY CLAIM NO.

THIS SERVICE STATUS BENEFITS EXHAUSTED FROM

PART II TO BE COMPLETED BY ATTENDING PHYSICIAN

PERIOD OF CARE REQUESTED (FROM) DATE (TO) DATE PRIM. DX CODE

CURRENT DIAGNOSES

A. (PRIMARY):

(SECONDARY):

NAME OF FORMER FACILITY FACILITY

B. DAILY MEDICATIONS (NAME, DOSAGE, FREQUENCY)

C. PATIENT'S GENERAL CONDITION, LIMITATIONS AND NURSING PROCEDURES REQUIRED:

☐ BEDRIDDEN ☐ TOTALLY INCONTINENT ☐ SPOONFEED ☐ CONFINED TO WHEELCHAIR ☐ AMBULATORY W. ASSISTANCE ☐ AMBULATORY SPECIFY

D. DIET

E. ATTENDING PHYSICIAN'S LAST VISIT (DATE):

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PHYSICIAN NAME & PHONE NO.

PHYSICIAN MEDI-CAL IDENTIFICATION NO.

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN DATE

PART III FOR STATE USE

18 PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED 2 APPROVED AS MODIFIED SEE COMMENTS BELOW

3 DENIED REASON AND ALTERNATE TREATMENT PLAN RECOMMENDED BELOW 4 DEFERRED

5 JACKSON VS RANK PARAGRAPH CODE

BY: (MEDI-CAL CONSULTANT)

X

ID NO DATE

REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

21 APPROVED CARE 22 SPECIAL PROGRAM

SNF ICF ICF DD M D SOB M D REHAB NO SPECIAL PROGRAM

FOCUS REVIEW

23 FROM (DATE) (Y/N)

24 THRU (DATE) (Y/N)

PROLONGED CARE ADMIN. DAYS (BED NOT AVAILABLE) PENDING (REQUEST FOR FAIR HEARING)

YES NO

25 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003(8)

TAR CONTROL NUMBER

OFFICE SEQUENCE

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.