THE OHIO STATE UNIVERSITY
HEALTH PLAN

AUTHORIZATION FORM FOR CONTINUED STAY FOR SNF, ECF OR LTACH

Instructions: Please print all requested information and submit this form to OSU Health Plan via email at**:** **UtilizationManagement.OSUHealthPlan@osumc.edu** or fax to: **614-292-2667.** Contact your OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form.

PATIENT INFORMATION: PRINT all information requested below

First Name__________________ Last Name______________________________________ DOB ____/____/____

Insurance ID # ______________ Diagnosis _____________________ICD-10________________; _______________

Admission Date _____________Review Date __________________Current Auth.#___________________________

FACILITY INFORMATION: PRINT all information requested below:

Facility Name____ Phone (_______)_________-_____________

Contact Name___________________________________ Phone (_____)________-___________ext.____________

Fax Number (______)______-____________ Email Address____

CLINICAL REPORT: PLEASE ATTACH INITIAL PT, OT, AND SLP EVALUATIONS WITH **FIRST** CONTINUED STAY REVIEW. INCLUDE CURRENT LIST OF MEDICATIONS, INCLUDING ANY IV/IM MEDICATIONS, A LIST OF TREATMENTS, AND PHYSICIAN PROGRESS NOTES WITH **EACH** UPDATE.

Height______Current weight__________Vital signs____

Code status_______________ Health Care POA Name___________________________ Phone__________________

NUTRITION: PO diet__________________ Tube feeds via_________ Formula/Amt _________________________

___Bolus____times per day OR via pump_____hours per day. TPN_____ hours per day_______________________

RESPIRATORY: Pulse ox readings_________Oxygen via___________@______liters/min____ CPAP__ BIPAP__

Trach-size ___________ type__________ Suction frequency/amounts____

Ventilator settings:____________________________________Weaning plan/progress_________________________

____

DIABETES MANAGEMENT (IFAPPLICABLE) Blood sugar range____________________Frequency of BGM________

Is patient independent in BGM?________Teaching needed?____

WOUNDS/PRESSURE ULCERS: PLEASE ATTACH INITIAL ASSESSMENT, MEASUREMENTS, CURRENT TREATMENT / PREVENTION PLANS.

HEMODIALYSIS: Facility name___________________Location___________________Days___________________

Venous access via AV fistula ____________Port ________PERITONEAL DIALYSIS_______ Frequency________

Was patient seen in Hospital ED or hospitalized since last clinical report? No___ Yes___ If yes, please explain________

____

Any falls or injuries since last clinical report?____

Physician appointments since last report?____

Upcoming appointments?____

****PLEASE NOTE: OSU HEALTH PLAN REQUIRES PRIOR AUTHORIZATION AND USE OF OUR IN NETWORK AMBULANCE PROVIDERS IF THE HEALTH PLAN WILL BE REIMBURSING FOR AMBULANCE OR WHEELCHAIR TRANSPORTING SERVICE.**

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PHYSICAL THERAPY-Fill out form even if evaluations are attached.

Please indicate the level of function: **I**=Independent; **MI**=Modified Independent; **D**=Dependent; **Min**=Min. Assist; **Mod**=Mod. Assist; **Max**=Max Assist; **Total**=Total Assist; **CGA**=Contact Guard Assist; **S**=Supervision.

Function	**PLOF**	**Goal**	**Initial evaluation date** ______________	**Date**	**Date**
Bed Mobility					
Transfers					
Ambulation					
Distance					
Assistive Device					
Stairs					
ROM-UE ROM-LE					
Wt. Bearing					
Strength					
Balance					
Endurance					

Has patient refused to participate in therapy since last clinical update? Yes No

COMMENTS____

____

Current amount of therapy___________ minutes/day &_____________________times/week.

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OCCUPATIONAL THERAPY-Fill out form even if evaluations are attached.

Please indicate the level of function: **I**=Independent; **MI**=Modified Independent; **D**=Dependent; **Min**=Min. Assist; **Mod**=Mod. Assist; **Max**=Max Assist; **Total**=Total Assist; **CGA**=Contact Guard Assist; **S**=Supervision.

Function	**PLOF**	**Goal**	**Initial evaluation date** ______	**Date**	**Date**
Grooming					
UB-Bathing					
UB-Dressing					
Toileting transfer					
Toileting hygiene					
Homemaking skills					
Strength-upper body					
Balance					
Endurance					

Has patient refused to participate in therapy since last clinical update? Yes No

Comments____

____

____

____

____

Current amount of therapy_________ minutes/day &________________________times/week.

SPEECH THERAPY-Fill out form even if evaluations are attached.

Function	**PLOF**	**Goal**	**Initial evaluation date** ______________	**Date**	**Date**
Dysphagia/ Swallowing					
Diet restrictions					
Articulation					
Aphasia					
Dysphasia					
Cognitive abilities					
Memory					
Problem solving					
Safety Awareness					

Has patient refused to participate in therapy since last clinical update? Yes No

Was MBS evaluation done? ___Yes ___No

Date_________________Results____

____

Comments____

____

____

Current amount of therapy_________ minutes/day &_________________________times/week

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DISCHARGE PLANNING/TRANSITION OF CARE-Standards of care require discharge planning from the day of admission. Please complete this form and submit with the initial continued stay request. If there are changes or updates during the course of care, include the information with each subsequent report. Indicate no changes/date at the bottom of the page.

Facility Discharge Planner name____ Title______________________

Direct phone number (_______)_______-__________ Email address _______________________________________

Date/time of care conference(s)____

Anticipated discharge date_______________ DC to______ own home___________other address ________________

____Phone___________________

If planning transition to another facility, please list type/address/phone_______________________________________

____

Does patient live alone?____________Is patient competent to make decisions?__________________________________

Behavior concerns____

Financial concerns____

Caregiver(s) Name(s)____________________________________Phone____________Relationship______________
Name(s)____________________________________Phone_____________Relationship________________________
Name(s)____________________________________Phone____________Relationship_________________________

Home environment: Is therapy planning a home assessment? If yes-date/time___________________________________

Type of home___ single level___ multilevel; Steps to enter_____Steps in home_______Ramp(s) needed?___________

Bed/Bath on what level________Barriers/Concerns____

Community Referrals: Home delivered meals; Home health aide; Homemaker; ERS; Transportation; Adult protective services. Please list type, name and phone numbers ____

____

Is patient a Veteran?______________________Services____

Home Care: RN PT OT SLP MSW (CIRCLE ALL THAT APPLY) ****Please note Home health aide is <u>not</u> a covered benefit under the Health Plan. In network home care providers must be used. A current list can be found on our website https://osuhealthplan.com/find-a-provider-search/#. or by calling customer service at 614-292-4700.**

Agency name____Phone_____________________________

DME ordered____

____

DME Company Name____ Phone_____________________________

****Must be an in network DME provider and prior authorization is not required for medically necessary items costing less than $2,000.**

Comments____

____

No change/Date________________ No change/Date___________ No change/Date__________ No change/Date__________ No change/Date______________

AUTHORIZATION FORM FOR CONTINUED STAY FOR SNF, ECF OR LTACH

Patient Name___________________________

TO BE COMPLETED BY OSU HEALTH PLAN

Level of Care: ☐ ECF ☐ SNF 1 ☐ SNF 2 ☐ SNF 3 ☐ SNF 4

☐ Approved for dates ________________________________ Next Review Date ___________________

☐ Denied – Reason ____

Comments ____

____

____

____

____

Case Manager Name ____ RN Telephone Number (_____)_____-_________

Email Address ____