

Inpatient Rehabilitation

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 (Last, First, MI):

Recipient ID:

DOB:

Phone:

Address:

City:

State:

Zip Code:

Guardian Name (if applicable):

Guardian Phone:

Medicare Insurance Information: Part A Part B Medicare ID#:

Other Insurance Name:

Other Insurance ID#:

ORDERING PROVIDER INFORMATION

Ordering Provider Name:

NPI:

Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

SERVICING / RECEIVING PROVIDER INFORMATION

Rehabilitation Facility Name:

NPI:

Facility Address:

City:

State:

Zip Code:

Phone:

Fax:

Contact Name:

CLINICAL INFORMATION

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

Check the box next to each deficit that applies: ADLs Ambulation Bowel Bladder
 Communication Cognitive Mobility Weight Bearing Restrictions

Ventilator: Yes No

Is a pressure ulcer present? No Yes: Location: _____

FIMS: _____

Stage: _____ Measurements: _____

Rancho Los Amigos Scale (for head injury):

Feeding Status:

Estimated Admittance Date: _____ Estimated Length of Stay: _____ days

Estimated Discharge Date: _____

Inpatient Rehabilitation

Rehabilitation Diagnosis Code	Description
1.	
2.	
3.	
Other Diagnosis Code	Description
1.	
2.	
3.	

Functional Deficits and Prognosis for Improvement:

Treatment Plan and Goals:

Discharge Plan, Destination and Available Support:

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