PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Passport Health Plan by Molina Healthcare
Long Term Acute Care Hospital (LTACH)

ADMISSION REQUEST

Member Name:	**DOB:**	**ID:**
Provider Name:	**Contact name:**	**Transfer date to LTACH:**
Anticipated LOS / DC:	**DC plan:**	

Expectation that this patient will require a 25-day length of stay? _____

This patient is stable for transfer to LTACH, as evidenced by:

Hypotension absent? ☐ Yes ☐ No	Cardiovascular status acceptable? ☐ Yes ☐ No	Stable chest finding? ☐ Yes ☐ No
Renal function acceptable? ☐ Yes ☐ No	Pain adequately managed? ☐ Yes ☐ No	Acute, severe or unstable neurological abnormalities? ☐ Yes ☐ No
Acute, significant hepatic dysfunction? ☐ Yes ☐ No	Active bleeding or unstable disorders of hemostasis? ☐ Yes ☐ No	Intake acceptable? ☐ Yes ☐ No
Isolation required? ☐ Yes ☐ No If Yes, Type:	Long-term enteral feeding? ☐ Yes ☐ No If yes: Formula, Rate, Frequency & Duration	TPN / Lipids? ☐ Yes ☐ No If yes: Rate, Frequency & Duration
Feeding tube and/or central line? ☐ Yes ☐ No	Other:	Other:

PLEASE LIST ALL LTACH SERVICES TO BE PROVIDED

IV ANTIBIOTICS: Medication name, dose, frequency, length of therapy/end date, reason for IV antibiotics. Type of line, central, Peripheral intravenous line:	**VENT:** Settings, weaning trials, suctioning frequency, nebulizer frequency. Trach specifics:
WOUND CARE: List all wounds inclusive of: location, size, description and care for each wound. Include the length of time to complete each wound(s) care procedure:	**REHAB SERVICES:** Provide each therapy discipline member will receive, inclusive of hours/day, days/week for each therapy. Include prior and current level of function:
LABS & DIAGNOSTICS: Frequency/Type:	**CONTINUOUS MONITORING:** Examples: Cardiac/Telemetry; Pulse Oximetry; 1:1 Sitter; Restraints, etc.:
NUTRITION: Tube feeds, TPN/Lipids listed above. Type of PO intake/diet:	**DAILY PHYSICIAN VISITS:** List all specialties that will follow at LTACH, inclusive of visit frequency:
OTHER IV MEDICATIONS: Med, Dose, Frequency (routine & PRN):	**OTHER:**

Multidisciplinary assessment completed and documented (ideally, including Palliative Care), and supports expectation that this patient will benefit from, and improve with a LTACH program? Describe:

To expedite the review process:

Limit the number of pages of documentation you submit with your auth request to only the minimum necessary clinical information. This includes: Recent MD progress notes; any changes in condition from prior review (I.E. Labs, Physical Findings); Procedure(s) performed; Most recent therapy notes – intake status and medication list.

Prior Authorization is not a guarantee of payment for services. Payment is made in accordance with a determination of the member's eligibility, benefit limitation/exclusions, evidence of medical necessity and other applicable standards during the claim review.