Molina Healthcare – Alternate Level of Care Request Form
Phone: 855-322-4077

Member Information		
Member Name:		**DOB:**
Member ID:		**Today's Date:**
Hospital Name:		**Hospital Admit Date:**
Facility Requested:		**Tentative Admit Date:**

Level of Care Requested:

☐ SNF/SAR ☐ Inpatient Rehabilitation ☐ LTAC

Hospital Contact Information:	CM/RN Name:	**Facility Contact Information:**	CM/RN Name:
	CM/RN Phone: **Confidential V/M?** ☐ Yes ☐ No		CM/RN Phone: **Confidential V/M?** ☐ Yes ☐ No
	CM/RN Fax:		CM/RN Fax:

Most Recent Vitals:		**Active Diagnosis (Include ICD-10 codes):**
BP:	**T:**	1.
P:	**Sp02:**	2.
	L RA / 02:	
R:		3.
Vent Settings:		4.
Current IV Meds:		**Pertinent Labs:**
End date: **Frequency:**		
Restraints: ☐ Yes ☐ No		

Living Arrangements: ☐ Lives alone   ☐ Lives with someone   ☐ Homeless   ☐ Other

Prior Level of Functioning before hospitalization: ☐ Independent   ☐ Contact Guard   ☐ Supervised   ☐ W/C Bound
☐ DME   ☐ Other

DOCUMENTS REQUIRED with this completed form for submission:	
- Facesheet/Demographics - H&P + Most recent attending MD progress notes - OT & PT notes – no older than 48h from date of request - PM&R note – no older than 48h from date of request (IPR only)	- Pt's prior level of function (DME used, level of assist needed and who assisted pt.) - Pt's prior living arrangements - LTAC: SPECIFIC documentation as to why pt. required LTAC level of care

**Therapy/Treatment notes within 3 days of discharge must be included with this request