Molina Transfer Request

Phone: 888-898-7969

Medicaid/Marketplace Fax: (800) 594-7404; Medicare/MMP Fax: (888)295-7665

Patient Name:	**Molina ID:**	**DOB/Age:**	**Today's Date:**
Molina LOB:	☐**Medicare** ☐**MMP / Duals**	☐ **Medicaid**	☐**Marketplace**
Hospital Name:	**Facility Requested:**		

Level of Care Requested Based on InterQual:

☐SNF/SAR (1 discipline – 1-2 hrs/5 days/wk)
☐SNF/SAR (4 hrs SN **OR** 1 discipline 2-3 hrs/5 days/wk)
☐SNF/SAR (IV abx, wound) (4 hrs SN **AND** 1 discipline 2-3 hrs/5 days/wk)
☐SNF/SAR (vent/dialysis)
☐ Inpatient Rehab
☐ LTACH
☐ Custodial (MMP only)

Hospital Admission Date:	**Tentative Admission Date:**

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

Most Recent Vital Signs:

BP: _____ **T:** _____

P: _____ **Sp02:** _____ **L RA / O2**

R: _____ **Wt:** _____ **Lbs / Kg**

Vent Settings:

Active Diagnosis (include ICD10 Codes):

1. _____

2. _____

3. _____

Current IV Meds: _____

End Date: _____ **Frequency:** _____

Restraints: ☐ Yes ☐ No

Pertinent Labs:

Living Arrangements/Social History:

☐ Lives alone ☐ Lives with someone ☐ Homeless ☐Other: _____

Prior Level of Functioning before hospitalization:

☐ Independent ☐ Contact Guard ☐ Supervised ☐ Wheelchair bound ☐ DME ☐ Other: _____

Required Documents:

Face sheet/demographics page	**Most recent admitting attending MD prog note**	**Pt's prior level of function (DME used, level of assist req, who assisted pt)**
Completed Transfer Request form	**OT note, no older than 48h from date of request**	**Pt's prior living arrangements**
H&P	**PT note, no older than 48h from date of request**	**PM&R note, no older than 48h from date of request (IPR only)**
		SPECIFIC documentation as to why pt required LTAC level of care

****Therapy/Treatment Notes within 4 days of discharge must be included with this request**

**** Make copies for future use. Disregard old copies.**