L.A. Care's Recuperative Care Prior Authorization Request

Is member interested in a voluntary recuperative care stay? ☐ Yes ☐ No **(If No, please stop and do not continue)**
Line of Business: Anthem, Blue Shield and Kaiser Medi-Cal members are not eligible

☐ DSNP ☐ L.A. Care Medi-Cal ☐ Dual Member

Please complete form and attach required documents. After completion, you may submit form via fax **213.536.0634**. Incomplete forms and/or missing document will delay decisions.

☐ Initial Referral
☐ Transfer Referral Request – ONLY to be used by Recuperative Care Site
☐ Retro Referral Request – ONLY to be used by Recuperative Care Site

Referral Source Information

Internal referring department* (select one): ☐ BH ☐ CM ☐ MLTSS ☐ SS ☐ Other: _____

External referral by* (select one): ☐ Clinic ☐ ECM ☐ Hospital ☐ PCP ☐ PPG ☐ Recup ☐ Other:_____

Referring Individual Name:* _____

Referring Organization Name:* _____

Referrer Phone Number:* ( ) _____

Referrer Fax Number:* ( ) _____

Member Information

Member's First and Last Name:* _____ _____

Member's Medi-Cal Client ID #* (CIN):* _____ Member Date of Birth:* _____

Member Address if known:* _____

Member Primary Phone Number:* ( ) _____ Best Time to Contact:* _____

Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other _____

Current Living Location:*

☐ Street ☐ Shelter ☐ Homeless ☐ Interim Housing ☐ LTC ☐ Recuperative Care ☐ Other _____

Hospital/SNF Admission Information*

Date of admission: _____/_____/_____ Reason for Admission: _____

Member's current hospital/SNF location, if applicable: _____

Diagnoses: _____

Mental Health History: _____

Height: _____ Weight: _____ Allergies: _____

Communicable disease: ☐ Yes ☐ No **If YES, please include documentation**

Colonized: ☐ Yes ☐ No **If YES, please include documentation**

L.A. Care HEALTH PLAN®

L.A. Care's Recuperative Care Prior Authorization Request

DIAGNOSIS*: Please answer ALL questions.

ADLs

1. Can Member Self Represent? ☐ Yes ☐ No
2. Is Member Independent w/ADLs? ☐ Yes ☐ No
   If NO, please explain _____
3. Self-administer all medication? ☐ Yes ☐ No
   If NO, please explain _____
4. Continent with bladder? ☐ Yes ☐ No
   If NO, can self-care be completed independently?
   ☐ Yes ☐ No
5. Continent with bowel? ☐ Yes ☐ No
   If NO, can self-care be completed independently?
   ☐ Yes ☐ No
6. Colostomy Care? ☐ Yes ☐ No ☐ N/A
   If YES, who is providing colostomy supply?
   _____
7. Catheter Care? ☐ Yes ☐ No ☐ N/A
   If YES, can it be done independently?
   ☐ Yes ☐ No
8. Can member perform wound care independently?
   ☐ Yes ☐ No ☐ N/A
   If NO, authorization and home health arrangements required prior to discharge.

DME Dependent

1. Walker ☐ Yes ☐ No
2. Cane ☐ Yes ☐ No
3. Crutches ☐ Yes ☐ No
4. Wheel Chair ☐ Yes ☐ No
   Please check one of the following:
   ☐ Manual Wheel Chair
   ☐ Electrical Wheel Chair
5. Oxygen ☐ Yes ☐ No
6. Please indicate how many liters' member will be discharged with ☐
7. Wound Vac ☐ Yes ☐ No
8. Bipap ☐ Yes ☐ No
9. CiPap ☐ Yes ☐ No
10. Other: _____

Substance Use

Alcohol ☐ Yes ☐ No
Cocaine ☐ Yes ☐ No
Heroin ☐ Yes ☐ No
Methamphetamines ☐ Yes ☐ No
Methadone Clinic needed? ☐ Yes ☐ No
Other _____

Additional Clinical Information

IV Antibiotics
☐ Yes ☐ No

If YES, please attach documentation

*Must obtain authorization for home health or infusion services prior to discharge.

Medical/Medication Management & Education
☐ Yes ☐ No

Wound Care ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Home Health: Must be arranged prior to discharge to recuperative care site*

Check here if the member does not have Home Health orders at this time. ☐

Name of Home Health Provider: _____

Phone #: ( )_____ Confirmation start of services _____/_____/_____

L.A. Care HEALTH PLAN®

L.A. Care's Recuperative Care Prior Authorization Request

Follow up appointments*

Prior to hospital discharge, please arrange PCP follow up appointments and obtain authorization for specialist care provider follow up.

Provider Name	Phone Number	Appointment Date/Time	Appointment Reason	Address

Please attach Documents: All documents with a red (*) are required upon submission.

- ☐ CXR or PPD (within last year*)
- ☐ Face Sheet*
- ☐ History & Physical*
- ☐ COVID-19 Test Required*
- ☐ Medication List*
- ☐ Psych Notes (if applicable) – should include the last 2 days of nursing documentation
- ☐ Consultation Notes (if applicable)
- ☐ Recent PT/OT/ Speech Therapy (if applicable) If member doesn't require PT/OT ST, provider to provide documentation that member is independent with ADLS.
- ☐ Wound Care Notes (if applicable)
- ☐ ONLY for Recuperative Care Transfers – (Please include hospital clinical documentation and recup site progress notes)

Request to Transfer into an L.A. Care Bed

ONLY for newly enrolled L.A. Care members currently in Recuperative Care

Name of Referred Hospital: _____

Initial Admission Date: _____ /_____ /_____

Days Authorized by Hospital: _____

Scheduled Exit on Initial Referral: _____ /_____ /_____

Requesting Start of Services: _____ /_____ /_____

Justification for Continued Stay: _____

_____

_____

_____

_____