



MEMBER NAME: _____ MEMBER ID: _____

DOB: _____ OTHER INSURANCE: _____ MEDICARE A B

EPSDT eligible member? Yes No CRS Eligible member? Yes No

REQUESTED PROVIDER: _____ ID: _____ PHONE: _____ FAX: _____

URGENCY STATUS (see * for definitions of status):

- Standard (Based on members' condition – Not to exceed 14 days)
- Expedited – Urgent (within 3 days)

Services Requested: _____

Date of Service: _____ Diagnosis Code: _____ Estimated Length of need: _____

Please answer the following questions:

1. Is member completely immobile? Yes No
2. Does member have limited mobility? Yes No
3. Does member have:
 - a. Impaired nutritional status? Yes No
 - b. Fecal or urinary incontinence? Yes No
 - c. Altered sensory perception? Yes No
 - d. Compromised circulatory status? Yes No
4. Describe each pressure ulcer:

LOCATION	STAGE	LENGTH	WIDTH	DEPTH	UNDERMINING	TUNNELING

Has member been on a comprehensive ulcer program for at least 20days, which includes education, frequent repositioning q 2hr, wound care, management of moisture incontinence, nutrition intervention? Yes No

Type of support surface tried _____

5. Over the past month, member's ulcer(s) has/have: Improved Remained the Same Worsened

6. Does member have a recent (within 60 days) myocutaneous flap or graft for ulcer on truck or pelvis?
Yes No If yes, give date of surgery _____

7. Was client on an alternating pressure or low air loss mattress or bed or an air-fluidized bed immediately prior to a recent (within 30 days) discharge from a hospital or nursing facility? Yes No

8. Was a comprehensive assessment performed after failure of conservative treatment? Yes No

9. Does member spend at least 20hours per day in bed? Yes No

10. Does member have coexisting pulmonary disease? Yes No

11. Is there a trained full-time caregiver? Yes No

For air fluidized beds only:

a. Will member require institutionalization without it? Yes No

b. Will there be a trained full-time caregiver to assist member and manage all aspects involved with use of the bed? Yes No

Please attach the following: (Mandatory)

1. Copy of the physician order (if referral not signed by PCP).
2. Results from recent CBC, TSH, serial blood sugars for diabetics, serum ferritin, iron studies, albumin.

Referring Provider Information:

Provider Name: _____ ID Number: _____ Contact: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Date: _____

PCP/PCP Designee Signature: _____

PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records.

***Standard Authorization Request:** This is a request that P/GLTC provides a decision as promptly as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to reach a decision.

Expedited Authorization Request: A request that P/GLTC provide a decision to the member as promptly as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to come to a decision.

Referral authorization is not guarantee of payment.