PINAL • COUNTY
Wide open opportunity

PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL

DME/SPECIALTY BED

PLEASE FAX ALL REQUESTS TO **(520) 866-6717**

Member Name: ______________________ ID# __________ DOB __________

Medicare A ☐ B ☐ Other Insurance ______________________

Name of Nursing Home/ALF ______________________

EPSDT eligible member? Yes ☐ No ☐ CRS eligible member? Yes ☐ No ☐

Service Provider Number: ______________________
(AHCCCS# of Provider referred to)

Service Provider Name: ______________________
(Name of Provider referred to)

Service Requested: ______________________

Date of Service ______________________

Diagnosis Code: ______________________ Estimated length of need (# of months): ______________________

Requested CPT Code: ______________________ Est. Cost: ______________________

URGENCY STATUS: ☐ Standard (Based on members condition – Not to exceed 14 days)
☐ Expedited – Urgent (within 3 days)

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 treatment program for at least 20 days, 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 trunk 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 20 hours per day in bed? Yes ☐ No ☐
10. Does member have coexisting pulmonary disease? Yes ☐ No ☐
11. If 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 ☐

PCP/PCP Designee Signature ______________________

PHONE: ______________________ **FAX:** ______________________

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

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

***Standard Authorization Request:** A request for which P/GLTC provides a decision as expeditiously as the member's heath condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension of the P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.

***Expedited authorization Request:** A request for which P/GLTC provides a decision to the member as expeditiously as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests an extension or if P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.